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BENEFIT DESIGN SPECIALISTS, INC.

Request for Reimbursement Claim Form

Employer Name:		**Email:**	
Employee Name:	Last First MI	**Last 4 of SSN:**	**XXX-XX-**
Employee Address:	Street City State Zip	**Phone#**	

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim

*Information below must be completed

MERP™ Plan

Date of Service MM/DD/YY	Patient Name	Name of Provider	Phone Number of Provider

HSA Plan

Please Process My Request As Follows (Select One):

☐ **No Reimbursement Requested – Please only enter my claims in the Claim Vault, I understand I may request payment in the future.**

☐ **Yes, Reimbursement Requested – Please enter my claims in the Claim Vault and process a Direct Deposit distribution.**

☐ **Reimbursement Only – No Claims to Submit to the Claim Vault at this time.**

☐ **Amount Requested For Distribution _____ (Select One)**

☐ **Direct Deposit Into Personal Checking Account on File**

☐ **Mail Check To Me (a fee of $3.00 for each paper check will apply)**

Reason For Distribution (Select One):

☐ **Normal Qualified Distribution**

☐ **Non-Qualified Distribution**

☐ **Disability/Death**

☐ **Withdrawal of Excess Contributions & Earnings**

☐ **Close Account and Distribute Remaining Balance**

☐ **Other**

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. Receipts from my service provider(s) for all expenses are attached to this voucher. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: ____/____/____

****There is a specific time limit each plan year that your claims can be submitted for reimbursement. Please refer to your Summary Plan Description for specific claims run-out information.**

Mail To: Benefit Design Specialists, Inc.
Attn: Claims Department
1 Kacey Court, Suite 100
Mechanicsburg, PA 17055

Questions: 717-766-8844

or FAX To: 855-296-1027
or E-MAIL To: Claims@bdsadmin.com