

# MEDICAL EXPENSE REIMBURSEMENT ACCOUNT CLAIM FORM

for Franklin & Marshall College

To request reimbursement, please complete this Claim Form, attach copies of appropriate documentation, sign and date. All required information applicable to your claim must be provided in order to process your claim. **Please return this completed form, plus documentation, to Significa Benefit Services.**

*I certify that all expenses for which I have requested reimbursement: (a) were incurred for services or supplies received by my eligible dependent(s) or me, (b) are eligible for reimbursement per the terms of the Franklin & Marshall College Flexible Spending Accounts Plan, (c) have not been or will not be covered by any other plan or program of any employer or other person, and (d) have not been or will not be deducted on my individual income tax returns. I authorize my Medical Expense Reimbursement Account balance to be reduced by the amount requested below.*

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

(your signature is required in order to process this claim)

Employee's Name: \_\_\_\_\_ College ID #: \_\_\_\_\_  
First Middle Last

Mailing Address: \_\_\_\_\_

Daytime Phone Number (w/ area code): \_\_\_\_\_

**In order to receive reimbursement, copies of supporting documentation must be attached. Please see the reverse side of this form for instructions. Provide all information required below for eligible expenses incurred during the plan year in which you were a participant, or through March 15 of the following year. Please retain a copy of this Claim Form and supporting documentation for your records, as Significa is unable to return original documents.**

SERVICE DATE	NAME OF PATIENT	NAME OF DRUG OR TYPE OF SERVICE	AMOUNT CHARGED
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
		<b>TOTAL Unreimbursed Medical Expenses:</b>	\$

*Please mail or fax your completed, signed Claim Form plus required documentation to:*

**SIGNIFICA BENEFIT SERVICES, P. O. BOX 7777, LANCASTER, PA 17604-7777**  
**PHONE: (717) 581-1300                      1 (800) 433-3746**  
**FAX: (717) 581-8379                        www.significabenefits.com**

*(over)*

## **Instructions / Required Supporting Documentation:**

An expense is *incurred* on the date the service is provided, not when you are billed or pay for the service. Expenses must be incurred during the plan year (calendar year) during which you are / were a participant in the Medical Expense Reimbursement Plan, or through March 15 of the following calendar year.

**To prevent processing delays, please complete all information required on the reverse side of this form, and attach required documentation for each expense submitted for reimbursement as follows:**

- For an expense covered under another benefit plan (including your spouse's benefit plan), provide a copy of the Explanation of Benefits (E.O.B.).
- For an expense not covered under another benefit plan (including your spouse's benefit plan), provide an itemized bill from the provider. The itemized bill must include:
  - the provider's name and address,
  - patient's name,
  - date of service,
  - type of service, and
  - the amount charged for the service.
- For a prescription drug or supply expense, the itemized bill must include:
  - a description of the item,
  - prescribing physician's name, and
  - the amount charged.

*(For privacy, the name of a prescription drug may be "blacked out" if the bill clearly shows that the requested reimbursement is limited to the co-pay amount.)*

- For an over-the-counter drug or medical supply, please provide a cash register (sales) receipt showing:
  - the drug name,
  - date of service, and
  - the price of the item.

**Canceled checks presented without other required documentation are not considered acceptable forms of verification of an expense.**

# DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

for Franklin & Marshall College

To request reimbursement, please complete this Claim Form, attach copies of appropriate documentation, sign and date. All required information applicable to your claim must be provided in order to process your claim. **Please return this completed form, plus documentation, to Significa Benefit Services.**

*I certify that all expenses for which I have requested reimbursement: (a) were for the care of qualifying individuals, (b) are eligible for reimbursement per the terms of the Franklin & Marshall College Flexible Spending Accounts Plan, (c) have not been or will not be covered by any other plan or program of any employer or other person, and (d) have not been or will not be deducted or taken as tax credits on my individual income tax returns. I authorize my Dependent Care Reimbursement Account balance to be reduced by the amount requested below.*

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

(your signature is required in order to process this claim)

Employee's Name: \_\_\_\_\_ College ID #: \_\_\_\_\_  
First Middle Last

Mailing Address: \_\_\_\_\_

Daytime Phone Number (w/ area code): \_\_\_\_\_

**In order to receive reimbursement, copies of supporting documentation must be attached. Please see the reverse side of this form for instructions. Provide all information required below for eligible expenses incurred during the plan year in which you were a participant. Please retain a copy of this Claim Form and supporting documentation for your records, as Significa is unable to return original documents to you.**

SERVICE DATE	NAME OF DEPENDENT	NAME, ADDRESS, AND FEDERAL ID OR SOCIAL SECURITY NUMBER OF PROVIDER OF SERVICE	AMOUNT CHARGED
			\$
			\$
			\$
			\$
			\$
			\$
			\$
		<b>TOTAL Dependent Care Expenses:</b>	\$

*Please mail or fax your completed, signed Claim Form plus required documentation to:*

**SIGNIFICA BENEFIT SERVICES, P. O. BOX 7777, LANCASTER, PA 17604-7777**  
**PHONE: (717) 581-1300                      1 (800) 433-3746**  
**FAX: (717) 581-8379                        www.significabenefits.com**

*(over)*

## **Instructions / Required Supporting Documentation:**

An expense is *incurred* on the date the service is provided, not when you are billed or pay for the service. Expenses must be incurred during the plan year (calendar year) during which you are / were a participant in the Dependent Care Reimbursement Account Plan.

**To prevent processing delays, please complete all information required on the reverse side of this form, and attach required documentation for each expense submitted for reimbursement as follows:**

- Attach an itemized receipt from the dependent care provider, including:
  - the dependent care provider's name and address,
  - the dependent care provider's Federal ID number or Social Security Number,
  - date of service, and
  - the amount charged for the service.

**Canceled checks presented without other required documentation are not considered acceptable forms of verification of an expense.**