ASR health benefits
Health Plan Management

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FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM

Please read the instructions printed on the reverse side of this form before completing the following information.

Company Name: Berrien RESA **Group Number:** 731

Part I: Employee Information (Please print)

Employee Name (Last/First/MI)	Date of Birth	Social Security Number
Employee Address		Daytime Telephone Number
City	State	Zip Code

☐ **Change of Address Submission** – Please check box if above address is a change from what ASR has on file.

Part II: Health Care Reimbursement Request

Type of Service Combine all same type of service expenses.	Total Paid	Dates of Service When combining Type of Service expenses, use earliest and latest dates of service in group.		Covered by insurance (Y/N)	Explanation of Benefits (E.O.B.) Included (Y/N)	Total Requested Amount
		Beginning Date	Ending Date			
Medical						
Vision						
Prescriptions*						
Dental/Orthodontics						
Other						
					Total Amount for All Services	

Part III: Dependent Care Affidavit and Reimbursement Request

	Dependent's Full Name	Date of Birth	Dates of Service		Total Requested Amount
			Beginning Date	Ending Date	
1					
2					
				Total Amount for All Services	

Provider Name: _____ **Tax ID Number:** _____

I provided Adult/Child Care Services to the above individual(s) in accordance with the amounts and dates that are requested:

Provider Signature: _____ **Date:** _____

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM.

Part IV: Employee Certification for Reimbursement

I hereby certify all of the following:

- The above information is correct.
- If I am an eligible individual who contributes to a health savings account (HSA), or my employer contributes to an HSA on my behalf, I understand that only my uninsured dental and vision expenses, preventive care expenses, and other expenses incurred after the minimum annual deductible under the high-deductible health plan is satisfied may be reimbursed from my Medical Reimbursement Program.
- *Any non-prescription drugs for which I am submitting claims are used for medical care as defined by the Plan.
- I have not received reimbursement previously for these expenses from my Flexible Spending Account(s) or any other plan.
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000.
- I have obtained, or have exercised due diligence to obtain, the taxpayer ID number or social security number of the person or business providing the dependent care. I understand that this number is required of me in order for the Plan to reimburse my dependent care expenses on a pre-tax basis. I also understand that I am required to include this information with my tax return on IRS Form 2441.

I understand all of the following:

- Reimbursement is not a guarantee that this payment is tax free.
- Reimbursement of dependent care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return.
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal income tax return.
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account(s). I hereby authorize ASR Corporation or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (including other insurers) in order to consider the claim for reimbursement under my Flexible Spending Account(s).

Employee Signature: _____ **Date:** _____