REQUEST FOR REIMBURSEMENT
SECTION 125 CAFETERIA PLAN
UNREIMBURSED MEDICAL EXPENSE FORM

SEND YOUR COMPLETED REQUEST FOR REIMBURSMENT FORM (WITH SUPPORTING DOCUMENTATION) TO:

ASSOCIATED BENEFITS CORPORATION
1415 28th STREET, SUITE 100
WEST DES MOINES, IA 50266-1450
Phone: 515-226-0303 or 800-747-4421
Fax: 515-226-8472

USE THIS FORM WHEN:

- **Requesting reimbursement for expenses that have previously been processed by your insurance plan.**
- **Requesting reimbursement for expenses that are not covered by any insurance plan.**

PLEASE NOTE: THIS IS NOT A MEDICAL OR DENTAL INSURANCE CLAIM FORM.

EMPLOYEE INFORMATION

Name	Social Security Number		Group #
Home Address	City	State	Zip
Employer	Employer City	Work Phone	

MEDICAL EXPENSE -- Itemize Each Expense

	PERSON RECEIVING MEDICAL CARE (Name and Relationship)	DATE(S) OF SERVICE (Date expense was incurred)	PROVIDER NAME (Doctor, Dentist, Pharmacy, etc.)	TOTAL OF EXPENSE	INSURANCE PAID/DISCOUNT GRANTED	AMOUNT REQUESTED
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
	TOTAL MEDICAL EXPENSES REQUESTED:			**$**		

PLEASE CHECK ALL BOXES THAT APPLY:

☐ The above charges are partially covered benefits under my health, dental, and or vision insurance coverage. Enclosed is an EXPLANATION OF BENEFITS form from my insurance company. NOTE: An Explanation of Benefits Form **IS REQUIRED** even if charges are applied to your deductible or out-of-pocket liability.

☐ The above charges **ARE NOT** a covered benefit by any insurance plan for which the patient is enrolled. Enclosed is an itemized receipt.

☐ The above charges are for reimbursement of my office visit or prescription drug co-payment due at the time of service. My insurance company does not provide an Explanation of Benefits form for these services. Enclosed is an itemized receipt.

EMPLOYEE CERTIFICATION — Reimbursement cannot be paid without your signature on this form.

I request reimbursement from the Employee Medical Reimbursement Account for the expenses itemized above. I certify that these expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code. I also understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. The information on the Request for Reimbursement is true and correct to the best of my knowledge.

EMPLOYEE SIGNATURE _____ **DATE** _____