BenePAY® Benefits, LLC

_____
Company Name

HEALTH CARE AND DEPENDENT CARE REIMBURSEMENT FORM

INSTRUCTIONS

Please complete the information below for Health Care/ Dependent Care Expenses for which you request reimbursement. You must provide information describing the service or product, the date of the services or sale, and the amount. For Health Care Expenses you must provide insurance EOBs, hospital or doctor bills, pharmacy receipts, or other evidence from independent third parties that the expenses were incurred. If you participate in HSA, and you are requesting reimbursement for deductibles, then you must provide information from a independent third party that the high deductible health plan has been satisfied. If you participant in HSA, and you are requesting reimbursement for "limited purpose" expenses, then you must provided information from an independent third party that the health care expenses are for vision, dental or preventive care. For Dependent Care Expenses, you must provide bills, receipts, or other evidence from dependent care provider or other evidence that expenses were incurred. No canceled checks please.

Last Name	First Name	MI	Social Security No.
Address			
City		State	Zip
Home phone	Alternate phone		E-mail address

EXPENSES

HEALTH CARE EXPENSES			
Patient	**Relationship**	**Date(s) of Service**	**Amount Requested**
		TOTAL:	

****Checks/direct deposits will not be written for less than $20. Requests for less than $20 will be applied to future requests.****

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DEPENDENT CARE EXPENSES				
Dependent Information		**Provider Information**		
Name/Age	**Relationship**	**Date(s) of Service**	**Name/Address**	**Amount Requested**
		From Thru		
		From Thru		
		From Thru		
			TOTAL:	

DISTRIBUTION OPTION AND SIGNATURE

Please choose your distribution option: ☐ **Check** ☐ **Direct Deposit**

Direct Deposit Routing #_____ Account # _____

****If different from payroll direct deposit account****

I request payment of the above expenses from my Health Care Account and/or Dependent Care Account for the attached health care and/or dependent care expenses paid or to be paid by me. I certify that these expenses are not eligible for reimbursement from any other source, and I will not seek reimbursement from any other source. I will not use expenses reimbursed through my Health Care Spending Account as deductions when filing my individual income tax return. I also will not use expenses reimbursed through my Dependent Care Spending Account as a tax credit when filing my individual income tax return.

Any detailed health information provided in this form will be kept confidential and will only be used for claim processing purposes.

_____ _____

Employee's Signature Date

MAILING AND QUESTIONS

Please sign this form and mail all receipts and/or supporting documents to:

Mail to:
BenePAY Benefits, LLC
FSA Department
P.O. Box 310
Byron Center, MI 49315

Email to:
egladding@benepayonline.com
and please "Request a Read Receipt"

Fax to:
616-575-8709
Attn: FSA Department

If you have any questions, please feel free to contact Erika at (616)277-5040.

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