



Flexible Spending Plan Reimbursement Voucher

*Please read the back of this form for instructions on how to complete this voucher *

YOUR EMPLOYER

YOUR NAME

S.S. NUMBER (Last 4 Digits)

YOUR ADDRESS (CHECKS WILL BE SENT TO THIS ADDRESS) CITY

STATE

ZIP

Please check this box if this is a change of address.

Email Address: _____

I authorize use of e-mail to communicate about this claim.

Unreimbursed Medical Expenses <i>Receipts must include description of service, date of service, and amount.</i>			Dependent/Child Care Expenses <i>Submit receipt including date of service, amount, and SS# or Tax ID# OR have provider fill out and sign below*</i>		
Nature of Service	Date(s)	Amount	Name of Day Care Provider	SS# or Tax ID#	
1		\$			
2		\$	Name of Dependent	Age	Disabled
3		\$			Yes <input type="checkbox"/> No <input type="checkbox"/>
4		\$	*Signature of Provider (if no receipt is attached)		Date
5		\$			
6		\$	Description of Service	Date(s)	Amount
7		\$	1		\$
8		\$	2		\$
9		\$	3		\$
10		\$	4		\$
	TOTAL	\$		TOTAL	\$

Premium Expenses

(Privately held insurance policies)

Type of Insurance	Dates of Coverage	Amount
	Total	

I authorize use of e-mail to communicate about this claim.

E-mail address: _____

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

SIGNATURE _____

Date _____

Send completed vouchers to:

Preferred Group Plans, Inc.
 P.O. Box 15136
 Albany, NY 12212-5136
 (518) 591-4960 (866) 989-8995
 Fax: (518) 641-0325
 www.thepreferredgroup.com

Minimum Request: \$25.00

++SEE REVERSE FOR DETAILS

*** HOW TO COMPLETE YOUR REIMBURSEMENT VOUCHER ***

FILLING OUT YOUR REIMBURSEMENT VOUCHER:

- Fill out *your* employer's name, *your* name and *your* address. The address on the voucher is the address to which your check will be sent. *If there is a change of address, please check the "Change of Address" box.*
- Be sure to fill in the last 4 digits of your Social Security Number and your home and work telephone numbers.
- *Sign* and date your voucher. Your claim cannot be processed without your signature.
- Please provide a specific description of your expenditures under the "description" column.
- Fill out the total amount of your claim in each category: Medical and Dependent Care.

SUBMITTING YOUR CLAIMS FOR REIMBURSEMENT:

- Please be sure that the claims that you are submitting for reimbursement are allowable expenses. There are some specific expenses that are not allowed under various Flex plans. For example, cosmetic procedures, child care while one spouse is at home, and premiums for group-term life insurance are not reimbursable expenses.
- You will need to attach *copies of third-party invoice(s)* to substantiate your claim. These may include receipts, insurance Explanation of Benefits (EOB) or other documentation. *Canceled checks cannot be accepted as proof of a reimbursable expense.* Each invoice must contain the following information:
 - *Date of Service.* Reimbursement is made based on date of service, not on date of payment.
 - *Nature of Service.* Receipts must specify the nature of service so that we may determine its eligibility under the Flex plan.
 - *Individual Receiving Service.* Only plan participants and their dependents may be eligible for Flex benefits.
 - *Amount of Service.* Please provide documentation indicating the cost of services for which you are responsible.

++UNREIMBURSED MEDICAL EXPENSES:

- Certain UNREIMBURSED MEDICAL EXPENSES may require a prescription from a licensed physician indicating the medical necessity, and condition, for which the items are required. A new prescription is required for each condition, and for continuing conditions at the beginning of each plan year.
- Certain FDA approved Over-the-Counter drugs and medicines which are used to treat an illness or injury may be reimbursed with a third-party receipt showing the printed date of purchase, description, dollar amount and name of provider.
- Expenses covered by your insurance can only be submitted to PGP *after* they have been submitted to your insurance carrier. When you receive your Explanation of Benefits, submit the *unpaid balance* to PGP. We cannot reimburse you before we know how much of your claim will be covered by your insurance carrier.
- Expenses *not* covered by your insurance should be submitted along with a statement from either you or your insurance carrier indicating that the expenses will not be reimbursed.

DEPENDENT DAY CARE

- For DEPENDENT DAY CARE claims please list your provider's name and either Social Security or Tax ID number.
- If no receipt is provided, please have your daycare provider complete the dependent day care section of this voucher and sign the appropriate box.*
- You can submit vouchers at any time, but you will only be reimbursed up to the amount that is in your Dependent Day Care Account at the time your voucher is received. The balance of the claim will be paid automatically as money is deposited in your account.

PREMIUM EXPENSE

- For PREMIUM EXPENSE claims, provide a third-party invoice showing the type of health related insurance the time period the insurance covers, the individual receiving coverage, and the amount of the premium. You will be reimbursed only for the coverage that falls within your plan year.

**If you have any questions regarding your Flex Account, please contact
The Preferred Group at (518) 591-4960 or (866) 989-8995
from 8 AM to 5 PM Monday through Friday.**