I05 Deductible Reimbursement Form

(THIS FORM SHOULD **NOT** BE USED FOR FLEX HEALTH CARE OR DEPENDENT CARE SAVINGS ACCOUNTS.)

EMPLOYER/COMPANY NAME _____

EMPLOYEE NAME: _____ **EMPLOYEE SSN** _____

STREET _____

CITY, STATE, ZIP_____

Please read the instructions on the back of this form before completing this voucher.

PLEASE NOTE: An Explanation of Benefits from your medical insurance carrier must be attached for reimbursement to be processed.

Name of Person Expense Covers	Date Service Incurred	Description of Expense including Name of Service Provider	Claim Amount
_____	_____	_____	
		_____	$_____
_____	_____	_____	
		_____	$_____
_____	_____	_____	
		_____	$_____
_____	_____	_____	
		_____	$_____

Please Read Carefully

I request payment for these expenses from my account(s). I certify that the above information is a true and an accurate statement of unreimbursed expenses incurred by **me or my eligible dependents** on the date(s) indicated, and were incurred while I was covered under my company's Plan. These expenses have not been nor will ever be reimbursed by another source or claimed on my personal income tax return. I understand that I may be liable for payment of all related taxes including Federal, State and/or City income tax on the amounts paid for any expense improperly claimed under the Plan.

Signature: _____ **Date:** _____

85 Washington Street • Keene, NH 03431 • 888-IPG-FLEX • (603) 358-6882 FAX

INSTRUCTIONS

ACCOUNT RULES AND CLAIM FILINGS:

- Only employees participating in the Plan may submit a claim voucher.
- Employees can submit a voucher at any time during the plan year and for a specified grace period after the plan year as described in their Plan's Summary Plan Description.
- Documentation supplied for processing will not be returned. Please use photocopies when possible.
- Substantiation must include the explanation of benefits from insurance carrier containing all information on the Claim Voucher. Canceled checks/credit card receipts/provider bills alone are not sufficient to document medical reimbursement claims.
- Claim eligibility is considered based on the dates of service not dates of payment.
- Claims cannot be processed unless ALL of the information on the voucher is completed.
- Payments will only be made directly to the employee.
- **PLEASE MAIL OR FAX COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:**

  IPG Employee Benefits

  85 Washington Street

  Keene, New Hampshire 03431

  Tel. (603) 357-2707 • 1-888-IPG-FLEX

  Fax (603) 358-6882

  Website: www.ipgflex.com

  Email: info@ipgbenefits.com