Flexible Spending Plan Reimbursement Voucher

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

Name of **EMPLOYER**

YOUR Name S.S. Number

YOUR Address **(CHECKS WILL BE SENT TO THIS ADDRESS)** City State Zip

☐ **PLEASE CHECK THIS BOX IF THERE IS A CHANGE OF ADDRESS.**

Home Phone # Work Phone #

Unreimbursed Medical Expenses

(Office Visits, Co-Pays, Vision, Dental, etc.)

Receipt must include Nature of Service, Date of Service, and Amount

Dependent / Child Care Expenses

(Day Camps, Babysitters, Daycare Centers, etc.)

Receipt must include Date of Service, Amount, and SS# or Tax ID#

☎ **Prescription for item # on file with PGP:** ☐

Nature of Service	*Date(s)*	*Amount*
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
	TOTAL	**$**

Name of Day Care Provider	*SS# or Tax ID #*
1	
2	

Description of Service	*Date(s)*	*Amount*
1		$
2		$
3		$
4		$
5		$
	TOTAL	**$**

Premium Expenses

(Privately held insurance policies)

Description of Service	*Dates of Service*	*Amount*
1		$
2		$
	TOTAL	**$**

This is to certify that I have incurred the expenses listed above for myself or qualifying dependents and that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans. I have enclosed copies of all bills for these expenses, including documentation of reimbursement to me, if any, provided by other health coverage. I have retained originals or copies of all documents submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed for 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, and the funds shall be re-credited to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

X

SIGNATURE ***Date***

Send completed vouchers to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(518) 641-0321 (800) 573-7474
Fax: (518) 641-0325

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 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, Dependent Care and Premium Expense.

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 spousal premiums for group-term life insurance are not reimbursable expenses. ***If you have any questions regarding an allowable expense, contact PGP for clarification.***
- 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. If you have already submitted the necessary documentation to PGP, be sure to indicate that by checking the box provided on the voucher under Unreimbursed Medical Expenses. ***Please contact PGP if you have any questions regarding the necessary documentation for expenses.***
  - 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 CARE**
  - For DEPENDENT CARE claims please list your provider's name and either Social Security or Tax ID number.
  - You can submit vouchers at any time, but you will only be reimbursed up to the amount that is in your Dependent 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 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) 641-0321 or (800) 573-7474 from 8 AM to 6 PM Monday through Friday.