

NORWICH UNIVERSITY
HEALTH CARE FLEXIBLE SPENDING
CLAIM FORM - _____ PLAN YEAR

This claim form is to be used only to request reimbursement from your Flexible Spending Account for health care expenses. When requesting reimbursement, the actual bill that you received, receipt of payment and/or other evidence that you have incurred the expense must be submitted with this claim form.

IN ALL CASES, YOU MUST SIGN THE BOTTOM OF THIS FORM AND COMPLETE THE REVERSE SIDE IN ORDER TO RECEIVE REIMBURSEMENT.

Employee (Please print)	Employee ID #
Address (Number, Street, City, State and Zip Code)	
Amount of Reimbursement Requested:\$ _____	

Are you participating in an HSA? If yes, who is covered? (Please check all that apply and see limitations on eligible expenses on the reverse of this form.)

You

 Spouse

 Dependents

(If expense is for a dependent-Please print or type-Attach additional sheet if needed)

Name of Dependent(s) (First, Last)	Date of Birth	If Full-Time (Y/N) Student/Name of School

I certify that the health care expenses being submitted for reimbursement meet the requirements as stated on the reverse of this form and I have indicated which category of expense to which they belong. Further, I understand that I have the responsibility for any tax or other legal reporting requirements with respect to reimbursed expenses. I also understand that, to the extent health care expenses are reimbursed under this Plan, they may **not** be claimed as expenses for purposes of the “itemized deductions” for medical care when preparing my Federal Income Tax Return or reimbursed through my HSA.

Employee Signature

Date

HEALTH CARE EXPENSES BEING SUBMITTED FOR REIMBURSEMENT MUST MEET THE FOLLOWING REQUIREMENTS:

1. The health care expenses were incurred by me or eligible members of my family during the period of January 1, _____ through December 31, _____ or the period that I was covered under this Plan, whichever is less.
2. I understand that health care expenses for the purposes of this Plan generally have the same meaning as defined in Section 213 of the Internal Revenue Code . •However, a participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the participant's spouse or individually maintained policies. Also, qualified long term care expenses as defined in Code Section 7702B(c) are not eligible for reimbursement. In addition, those Participants, including spouses and dependents thereof, who have elected to participate in a Health Savings Account (HSA) are limited to allocations and reimbursements for dental, vision, and “preventative care” expenses incurred by you and your dependents under the Health Care Flexible Spending Account.
3. These health care expenses were not eligible for reimbursement by either my employer’s or my spouse’s employer’s, if applicable, employee benefit plan or any other insurance policy.
4. These health care expenses for which I am asking reimbursement, have actually been, or will be, paid by me.
5. These health care expenses were for one or more of the 'following categories of expenses (Please check appropriate item) :

____Deductible and/or co-payment (attach Explanation of Benefits)

____Charges in excess of reasonable and customary allowances, which I am obligated to pay
(Attach Explanation of Benefits)

____Expenses that were not covered under employee benefit plans or other insurance policies. Some examples would be vision care; hearing care; routine physical; checkups; well-baby care; palliative foot care; smoking cessation, fitness programs (weight loss, etc.) prescribed by a physician; drugs or medicines whether purchased by prescription or over-the-counter, non-medical ancillary services and long-term rehabilitation services for substance abuse; non-educational treatment of development disabilities; educational treatment in Internal Revenue Code Section 213 qualified school; and cosmetic surgery to improve a deformity arising from a congenital abnormality, a personal injury from an accident or trauma, or a disfiguring disease. In addition, those participants who have elected to participate in a Health Savings Account (HSA) are limited to allocations and reimbursements for dental, vision, and “preventative care” expenses incurred by you and your dependents under the Health Care Flexible Spending Account.

____Other (Please describe)_____

FOR OFFICE USE ONLY: Date Received:_____ FSA-HC-BAL \$_____

Paid Previously: Yes:_____ No:_____ Date Paid:_____ By:_____

Reason Declined:_____