MedBen Group #____________

LIMITED PURPOSE HEALTH CARE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

LIMITED PURPOSE HEALTH CARE SPENDING ACCOUNT (Employee and/or Dependent, DENTAL & VISION Expenses ONLY **this option is only available to those participants enrolled in the HSA Plan)**

Employee Name: ________________________________ SS#: ________________________

Address: ____

Instructions: Complete the information below for medical expenses incurred by you, your spouse or other eligible dependents, for which you request reimbursement under the Employers Limited Purpose Health Care Spending Account Plan. Then date and sign the form. **Send this form along with your supporting documentation to: MedBen, Specialty Services Unit, 1975 Tamarack Rd., P.O. Box 1096, Newark, OH 43058-1096.**

	Expense # 1	**Expense # 2**	**Expense # 3**	**Expense # 4**	***EXAMPLE***
Date Service Was Actually Provided					*10-7-99*
Name of Person Receiving Medical Service/Relation to You	___ Self ___ Spouse ___ Dependent	___ Self ___ Spouse ___ Dependent	___ Self ___ Spouse ___ Dependent	___ Self ___ Spouse ___ Dependent	*Jane Doe* *_X_ Self* *___ Spouse* *___ Dependent*
Type of Service					*Eyeglasses*
Reimbursement Requested	$	$	$	$	*$ 100.00*

Total Reimbursement Requested $ __________________

To the best of my knowledge and belief, my statement in this Reimbursement Request Form is complete and true. I certify that I or my family member has received the services described above on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Employers Plan or any other Health plan, FSA plan or HRA plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is for prescription drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

______________________________ ______________________________
Employee's Signature Date

Required supporting documentation:

- A bill or receipt (including date of service, name of patient, provider name-address, amount, and type of service) from a dentist, orthodontist, ophthalmologist or other supplier;
- Explanation of benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the dental or vision plan(s) under which the employee or any eligible dependents are covered;
- Store receipts are acceptable ONLY for contact lens solution, eyeglasses, etc. The receipt MUST HAVE the following information printed on the receipt: Store name, date of purchase, Product name and amount of product.

Cancelled checks, handwritten receipts, credit/debit card transaction receipts or previous balance receipts cannot be used to verify an expense.