

THE CITY OF RENTON

REQUEST FOR REIMBURSEMENT HEALTH CARE

Please print or type

Employee (Last Name, First Name, Middle Init.)

Social Security Number

Address

Please be sure to staple documentation of services provided to the back of this claim form. Acceptable documentation is: 1) Explanation of Benefits (EOB) from the insurance company; 2) statement or bill from the health care provider that shows date of service and your financial responsibility; or 3) for contact lens supplies and co-payments only, a receipt.

City State Zip

To be eligible for reimbursement, health care expense must be for you, your legal spouse, or dependent as defined by the IRS. Furthermore, the expense must be for services performed during the plan year; and not be covered by any other health insurance (i.e. an out-of-pocket expense).

Daytime Phone (very important)

INSTRUCTIONS

Fill in the information below for health care expenses incurred by you or your eligible dependent. Each expense item must be accompanied by a receipt or bill or copy of your receipt or bill stating the DATE OF SERVICE. *Do not attach receipts or bills, which do not identify your expense as a health care expense.* NOTE: Expenses covered under a medical, dental, or vision or hearing plan must be submitted under that plan first. **ATTACH A COPY OF THE EXPLANATION OF BENEFITS YOU RECEIVED FROM THE INSURER OR A CO-PAY RECEIPT.** Please keep a copy for your records.

Date Expense Incurred	Name & Relationship of Person Incurring Expense	Description of Service/Expense	Name of Service Provider	Your Unreimbursed Expense
				\$
TOTAL Medical Care Expense Claim:				\$

CERTIFICATION BY THE PLAN PARTICIPANT

I certify that I am responsible for the validity of this claim and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant _____ Date _____

**SEND COMPLETED CLAIM FORM TO OUR ADDRESS:
PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS
AND DOCUMENTATION! A FEE WILL BE CHARGED FOR
ALL REQUESTED COPIES!**

Benefit Administration Company
P.O. Box 550
Seattle, WA 98111-0550
(206) 625-1800 www.baclink.com
(206) 682-8016 FAX (Note: If faxing claim **do not** mail original.)

Health Care and Dependent Care Claim Form Instructions Bulletin

REQUEST FOR REIMBURSEMENT

Prompt claim processing is largely dependent on the submittal of a properly completed Request for Reimbursement form (Health Care -vs.- Dependent Care Reimbursement). A properly completed form includes.:

- Legible personal information (employee name, social security number & current address)
- Employer Name (when not using a preprinted form from your HR office)
- A marked change of address box, if applicable
- A legible, itemized statement and/or receipts from your provider
- An Explanation of Benefits (EOB) from all health insurance carriers
- Claim total
- Employee SIGNATURE
- A separate claim form for each plan year

CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check-printing date will be processed in that check run. If you submit your claim request via facsimile, the deadline is 1:00 p.m. before the 72-hour cutoff. For example, if your plans' check printing date is Friday, the check run will include all forms received by 1:00 p.m. on Tuesday. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

Please retain a copy of your Request for Reimbursement Form, along with all supporting documentation for your itemized expenses.

CHECK STOP PAYMENT AND/OR CHECK REISSUE REQUESTS

Benefit Administration Company (BAC) will process check stop payment and/or reissue according to the following guidelines:

- All stop payment requests will be held for a minimum waiting period of ten business days from the original check release date.
- Once BAC has placed the stop payment with the financial institution, the reissued check will be held for 2 business days in accordance with the financial institution's requirement.
- **A \$30 processing fee will apply for all stop payment/reissued checks not resulted from a BAC error**
- BAC will issue a replacement check for a damaged original check only after the original check has been returned to BAC

OTHER HELPFUL HINTS

- * Eligible expenses are determined by the date of service, NOT the date of payment is made to the provider. Therefore, canceled checks, bank statements, credit card receipts and provider balance forward statements are not acceptable documentation.
- * A Dependent Care claim may be submitted up to 3 months in advance of services rendered
- * Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- * IRS rules require that the balance remaining in your reimbursement account (health care and/or dependent care) be forfeited at the end of the plan year.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- Health Care Spending Account: weight loss programs; cosmetic surgery; teeth bleaching
- Dependent Care Spending Account: overnight camp, diapers, late payment charges and care provided while you or your spouse are not working