



www.benstrat.com

FOR PARTICIPANTS

FAX CLAIMS TO:.....(603)-647-4668
 CLAIM SUPPORT.....(603) 647-4666
 MAIL TO:PO Box 1300, Manchester, NH 03105-1300
 ONLINE ACCOUNT.....<https://benstrat.navigatorsuite.com/Login.aspx>

CLAIM FORM : Health Care and Dependent Care Spending Accounts

Name: _____ Company: _____
 Home Mailing Address: _____ Check if NEW SSN: _____
 Address: _____ Plan Year: _____ -to- _____
 City: _____ State: _____ Zip: _____ Telephone: Home: () - _____
 Email: _____ Daytime Phone: () - _____

ListEXPENSES REQUESTING REIMBURSEMENT..... Use second sheet if needed.

Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.

Amount to be Reimbursed:	Service Date(s)	DESCRIPTION			Person receiving product or service:
1.		<input type="checkbox"/> MEDICAL	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
2.		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
3.		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
4.		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
\$	REQUIRED ... Date(s) of Service Start: _____ End: _____			CHILD CARE	

\$ _____ TOTAL Reimbursement Requested (Payments are made directly to the employee.)

CHILD / DEPENDENT CARE PROVIDER RECEIPT (May be used in lieu of other child care documentation)

Dependent(s) Receiving Care: _____

I certify that I have provided the services as listed above, and that I have been paid for these services.

Service Date Span: From _____ To _____

Provider's Name: _____

Provider's Signature: _____

INSTRUCTIONS / REMINDERS

- Be sure to attach a **COPY** of the itemized receipt(s), or if you have insurance, please send the Explanation of Benefits Statement. **KEEP** original receipts for your tax records.
- Complete** claims received by NOON on Thursday will be processed on Friday.
- The **participant** must **sign** claim form.
- Incomplete forms **will NOT be** processed.

Health Care Reimbursement Account documentation may include statements, itemized bills, and/or insurance "Explanation of Benefits" forms.

All documentation must show:

- the date the expense was **incurred** (not the date paid),
- the provider of services.
- a description of the service and/or expense.
- the amount of the expense for which you are responsible.

Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred by my legal dependents or myself. I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction.

EMPLOYEE SIGNATURE: _____

(Required)

Date: _____

ListEXPENSES REQUESTING REIMBURSEMENT

Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.

Amount to be Reimbursed:	Service Date(s)	DESCRIPTION			Person receiving product or service:
		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
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		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	
		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> OTC	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Rx	<input type="checkbox"/> _____	

\$ _____ **TOTAL Reimbursement Requested**

(Payments are made directly to the employee.)