

# Universal Claim Form

## Step 1: Claim Information

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of pages: \_\_\_\_\_

Plan year beginning for: 20\_\_\_\_

New Claim

Resubmission of claim

Response to claim denial

## Step 2: Participant Information

\*=Required Fields

\*Employer Name (Do not abbreviate)

\*Participant Name (First, MI, Last)

\*Participant Mailing Address  Check here if change of address

\*City

Department

 -  - 

\*Social Security Number

Email Address (If provided, all notifications will be sent via email)

\*State

\*Zip

## Step 3: Reimbursement Request

- Medical Reimbursement Account (FSA)
- Dependent Care Reimbursement Account
- Individual Premium Reimbursement Account

- Adoption Assistance Reimbursement Account
- 105(h) Health Reimbursement Account (HRA)

*Employee, Spouse or Dependent Name	*Amount Requested	*Date of Service	*Type of Service

**Total Amount Requested: \$ \_\_\_\_\_**

**Please note the following requirements for claims submission:**

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do **NOT** consider cancelled checks as valid documentation.
- Previous balances are **NOT** acceptable.
- All reimbursements will be made payable to the employee.

Minimum Reimbursement for manual claims: \$25

**\*\*Sign up for Direct Deposit TODAY\*\***

## Step 4: Authorization

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my account be reduced by the amount requested.

SIGNATURE OF PARTICIPANT \_\_\_\_\_ DATE \_\_\_\_\_