MedBen Group # 10225

ANTIOCH UNIVERSITY
Premium Reimbursement Request Form (FSA – M2)

Employee Name: ___________________________________ SS#: ___________________

Address: ____

Instructions: Complete the information below for Non-Employer Sponsored Health Insurance Premium incurred by you, your spouse or other eligible dependents, for which you request reimbursement under the Employers Premium, Reimbursement Plan. You must provide a copy of the bill or other evidence that the expenses were incurred. Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. 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*
Provider Name					*ABC Company*
Total Expense	$	$	$	$	*$ 100.00*
Amount Reimbursed Previously, or Paid/Payable under Another Plan	$	$	$	$	*$ 0.00*
Reimbursement Requested	$	$	$	$	*$ 100.00*

Total Reimbursement Requested $ ______________

To the best of my knowledge and belief, my statement in this Premium 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 premium expense 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. 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 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 carrier. Employees may not submit proof of payment in the form of a cancelled check or credit/debit card receipt unless it is accompanied by the other required documentation.