Section 125 – Flexible Benefit Plan
2013 Reimbursement Request Form

Section 1: Employee Information

Employee Name	Social Security or Employee ID #	Employer Name
Home Address (check if new address ☐)		Daytime Phone

Section 2: Health Care Reimbursement Request

Attach proper documentation showing the date(s) of service, type(s) of service and cost. **(No cancelled checks, balance forwards or bank card receipts will be accepted.)** Itemize all expenses to prevent delay in reimbursement. If you require additional space, please attach a separate page with the below information.

Dates of Service	Type of Service	Name of Provider	For Whom	Net Cost
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Health Care FSA Request**	**$**

Section 3: Dependent Care Reimbursement Request

Attach proper third-party documentation showing the date(s) of service, cost of service, name of child and provider's information. Note: the provider Tax ID or Social Security Number must be provided. If you require additional space, please attach a separate page with the below information.

Start Date	End Date	Provider's Name, Tax ID or SSN	Name of Dependent	Age	Cost
See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information.			**Total Dependent Care FSA Request**		**$**

Section 4: Premium Expense Reimbursement Request

Attach proper third-party documentation showing the period of coverage as well as the associated premium. The amount requested is only for individual health insurance premiums, not group plans and cannot be reimbursable through any other program. If you require additional space, please attach a separate page with the below information.

Coverage Period	Insurance Carrier	Covered Person(s)	Reimbursement Request

Section 5: Signature and Certification

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Care (HCFSA), Dependent Care Flexible Spending Account (DCFSA) or Premium Expense Reimbursement Account (PERA), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFSA, DCFSA or PERA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFSA, DCFSA or PERA which relate to such expense. I further understand that no dependent care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or eligible dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance.

Employee Signature: ______________________________ Date: ______________

Please submit this form with your claim documentation to:

PRO Benefits Administrator
PO Box 1255
Detroit Lakes, MN 56502-1255
Phone: 218-847-9277
Toll Free: 800-776-4671
Fax: 218-847-2173
Email: brandi@peohrpro.com

This form available online at www.peohrpro.com.