FLEXIBLE BENEFIT PLAN – REIMBURSEMENT REQUEST

Complete the following for expenses incurred by you, your spouse, or eligible dependents. Be sure to complete all information requested on this form. Any missing information may result in a delay in processing your request. **NOTE:** Keep expenses for different plan years separate – **ONLY ONE PLAN YEAR PER CLAIM FORM**. Please type or print the information. Remember to sign and date the form.

Plan Year	Group #	ID #
Group Name		
Employee Name		

Note – If you are submitting a claim for over the counter (OTC) drugs or medicines you must also provide a Letter of Medical Necessity (LMN), a copy of which may be found on our website at ***www.r1benefitstoday.org***.

Dates of Service	Service Provider Name	Person Receiving Services	Claim Amounts		
			Medical	Dependent Care	Private Insurance
___/____/___ To ___/____/___		Myself ☐ Spouse ☐ Dependent ☐	$	$	$
___/____/___ To ___/____/___		Myself ☐ Spouse ☐ Dependent ☐	$	$	$
___/____/___ To ___/____/___		Myself ☐ Spouse ☐ Dependent ☐	$	$	$
___/____/___ To ___/____/___		Myself ☐ Spouse ☐ Dependent ☐	$	$	$
___/____/___ To ___/____/___		Myself ☐ Spouse ☐ Dependent ☐	$	$	$
___/____/___ To ___/____/___		Myself ☐ Spouse ☐ Dependent ☐	$	$	$
		Reimbursement Request Totals	$	$	$

If you did not provide a valid proof of payment for Dependent Care claims submitted above, your dependent care provider must sign in the box below to certify that services were provided for the claims being submitted.

I certify that the Dependent Care services being claimed was provided by me on the dates indicated.

Dependent Care Provider Signature

By submitting this form, I certify that this is a valid claim for incurred eligible expenses as defined by the IRS, and the information provided is complete and accurate to the best of my knowledge. I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Region I, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement, and I will be liable for the payment of all related taxes and amounts paid from the Plan related to such expenses. I understand that the reimbursed expenses should not be claimed on my income tax return and I will retain a copy of all submitted documentation in the event of an IRS audit. For dependent care expenses submitted, the providers Tax ID (TIN) has been obtained and by me and will be included on the appropriate form of my federal income tax return. I understand it is my responsibility to notify Region I of any changes in the information provided.

Signed ____________________________________ Date ____________________

Print two copies. One for you and send the other one to:

Flexible Benefit Plan
3031 17th St. S.
Moorhead, MN 56560

800-450-2990 or 218-236-2990 - Fax 218-236-2368
www.r1benefitstoday.org

Office Use