



MAIL TO: REIMBURSEMENT ACCOUNT
 P.O. BOX 1140
 EXETER, NH 03833-1140
 Fax: 603-773-4415
 Telephone: 888-678-3457

REIMBURSEMENT REQUEST FORM

| | |
|---------------------------------|--------------------------------------|
| NAME | EMPLID or Social Security Number: |
| ADDRESS (STREET) | EMPLOYER: UNIVERSITY OF MAINE SYSTEM |
| ADDRESS (CITY, STATE, ZIP CODE) | LOCATION/DIVISION |

HEALTH CARE ACCOUNT

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other), under Type of Expense.
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.
- Attach a second form if you need additional space.

| TYPE OF EXPENSE | EXPENSE FOR: | | DATES OF SERVICE: | | TOTAL BILL (ATTACH COPY) | PLAN PAYMENT (ATTACH PAYMENT OR DENIAL) | AMOUNT OF REIMBURSEMENT DUE |
|-----------------|--------------|--------------|-------------------|----|--------------------------|---|-----------------------------|
| | FIRST NAME | RELATIONSHIP | FROM | TO | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| TOTALS | | | | | | | |

DEPENDENT CARE ACCOUNT

- You must have an itemized bill (or have the provider sign this form) and the taxpayer ID Number from each person providing care.
- List each dependent receiving care on a separate line. List each provider on a separate line.
- Attach the appropriate documentation information.

| DEPENDENT'S FULL NAME | AGE | RELATIONSHIP | DATES OF CARE: | | NAME OF PROVIDER OF CARE | AMOUNT (ATTACH PROOF OF EXPENSE INCURRED) |
|---|-----|--------------|----------------|----|--------------------------|---|
| | | | FROM: | TO | | |
| FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER: | | | | | | |
| | | | | | | |
| FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER: | | | | | | |
| | | | | | | |
| FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER: | | | | | | |
| TOTAL | | | | | | |

1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.
5. I have received the taxpayer ID # of my care provider.

SIGNATURE _____ DATE: _____

SIGNATURE OF CARE PROVIDER _____ DATE: _____

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE.