



Specializing in Benefit Administration

Select Data Service Administrators, Inc.

P.O. Box 2076, Batesville, Arkansas 72503
Phone: (888) 698-1429 FAX: (888) 877-4747

Claim for Reimbursement

(Instructions on reverse side)

Please keep the yellow copy for your records.

CHECK IF ADDRESS CHANGE

View your account on-line at www.selectdataservice.com

SECTION I - PERSONAL INFORMATION

Form with fields: Your Employer's Name, Your Name, Your Social Security Number, Mailing Address, Work Phone, Home Phone, City, State, Zip

SECTION II - DEPENDENT DAYCARE EXPENSE CLAIMS

Table with columns: Name of Dependent(s), Period Covered (From, To), Name, Address and Taxpayer Identification Number of Provider of Service, Amount Incurred. Includes a row for TOTAL DEPENDENT CARE EXPENSE CLAIMS.

Provider Signature (Not necessary if submitting receipt)

SECTION III - UNREIMBURSED MEDICAL EXPENSE CLAIMS - YOU, YOUR SPOUSE AND DEPENDENTS

Table with columns: Date Service Provided, Name and Address of Service Provider, Service Description, Person for Whom Expense Incurred, Net Amount After All Insurance Payments. Includes a row for TOTAL MEDICAL CARE EXPENSE CLAIMS.

Documentation showing all required information (see instructions) or the provider's signed statement must be attached.

SECTION IV - OTHER: THIRD PARY MEDICAL INSURANCE CLAIMS AND/OR QUALIFIED PARKING AND TRANSPORTATION

Table with columns: Date of Service / Coverage, Name and Address of Service Provider, Expense Description, Person for Whom Expense Incurred, Net Amount. Includes a row for TOTAL SECTION IV EXPENSES CLAIMED.

SECTION V - CERTIFICATION

The undersigned participant in the Pretax Plan certifies that all expenses for which reimbursement is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses, and that these expenses have not previously been reimbursed and are not reimbursable under any other health plan coverage.

Employee Signature and Date fields

Procedures for Submitting Claims

In order to receive reimbursements on your Pretax Plan, all claims should have the following information:

Section I:

1. Employee or participant's name, address, work and home telephone number
2. Employer's name
3. Employee's social security number

The following information must be listed on **ALL RECEIPTS AND THE CLAIM FOR REIMBURSEMENT FORM:**

1. Date the service was provided
2. What service was provided
3. Name and address of service provider
4. Person who received service
5. Net amount of service

A provider's signature **or** receipt is required with your claim for reimbursement. Please submit copies of your receipts and keep the original receipts for your records.

Section II: Dependent Day Care Expense

Dependent Child Care and Day Care expenses are listed in this section. List the Dependent's name, dates the services were provided, the name, address, and tax identification number of the provider of services and the amount of services. If the provider of service does not have a tax identification number, a social security number is acceptable. You **cannot** claim registration fees, activity fees (ie., gymnastics, dance etc.), or snack fees.

For Temporary Absences of two consecutive calendar weeks and where you are gainfully employed, you are not required to allocate expenses during that time. Temporary absence from work for vacation or minor illness, provided that care giving arrangements require you to pay for care, is eligible for reimbursement. Absences for more than two weeks are determined based on the facts and circumstances.

Section III: Unreimbursed Medical Expense

Medical Services for yourself, spouse, and dependents are listed in this section. Medical Services for example include physician visits, hospital visits, surgery, lab work, dental, optometry, and prescriptions.

The following are not allowable under Code Section 125 of the IRS:

1. Canceled Checks or Credit Card receipts as documentation
2. Billings that list previous balance, balance forward, or paid on account
3. Amount paid by insurance
4. Services—**WEIGHT LOSS, HOME IMPROVEMENTS, PLASTIC SURGERY, and DIET COUNSELING**

Unless they are medically necessary and a physician's letter is required.

Section IV: Other: Third Party Medical Insurance and/or Qualified Parking and Transportation

Cancer and Health premiums that are not payroll deducted through your or your spouse's employer are listed in this section. Proof of Policy must be submitted with your claim.

Qualified parking and transportation plan expenses are listed in this section. Documentation may be submitted in the form of parking receipts, used transit vouchers or passes, or copies of unused transit vouchers or passes for future services. Documentation is not required for metered parking expenses; reimbursement may be obtained for these services by completing the claim form.

Section V: Signature and Date

Sign and date your claim for reimbursement and mail to: Select Data Service Administrators
P.O. Box 2076
Batesville, AR 72503

If you have questions regarding how to complete your claim form, please call our Customer Service Department at 1-888-698-1429 or (870) 698-1429. You may fax your claim to **(888) 877-4747** attention Cafeteria Plan Administration.

If you fax your claim please **do not** mail the original.

Copy of Claim: Please keep a copy of your signed form and your original receipts. A photocopy is as valid as the original.