Please **STAPLE** all documentation to the back of this form in this corner

Flexible Benefits Program Request for Reimbursement

This is a two page form. Be sure it has a back side

EMPLOYER NAME: *TC3 - Group 996*

1 EMPLOYEE INFORMATION

Employee Name

Street Address

City, State, ZIP

SS# or ID #

2 CLAIM INFORMATION *(See back side of this form for instructions)*

The Plan will reimburse you the maximum amount your are eligible for. Please inform us if you are specifically requesting a lesser amount.

Circle Account	Provider of Service	Covered Person	Date(s) of Service	Amount to be reimbursed
Medical Dependent Care				
Medical Dependent Care				
Medical Dependent Care				
Medical Dependent Care				
Medical Dependent Care				
Medical Dependent Care				
Medical Dependent Care				

Medical means unreimbursed medical/dental/vision expenses
Dependent Care means day care/child care

3 SIGNATURE

I request payment from my Flexible Benefits Account(s) for the expenses itemized above. I certify that I have not received reimbursement under this Plan or form any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I also certify that the total dependent care expense(s) (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that I have met all the requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature

Date

SIEBA LTD
SPECIALISTS IN EMPLOYEE BENEFIT ADMINISTRATION

FLEXIBLE BENEFIT CLAIMS PROCEDURE

1. Complete a claim form with EVERY submission. BE SURE ALL INFORMATION IS COMPLETE.

2. STAPLED to the claim form should be legible copies of documentation to support your request for reimbursement.

THIS DOCUMENTATION MAY INCLUDE, BUT IS NOT LIMITED TO:

A. Explanation of benefits from all health benefit carriers involved, if applicable.

B. Copies of walkout statements noting co-pay amounts, bills, or itemized prescription receipts.

THIS DOCUMENTATION MUST BE ITEMIZED AND SHOULD INCLUDE:

- Name of Provider of Service
- Address and Tax ID # of Provider
- Patient's Name
- Date of Service
- Type of Service Provided (i.e. "office visit", "x-ray", etc)
- Charged Amount for each Service Provided
- Health Benefit Payments (if applicable) made toward the charge for each date of service

Statements showing ONLY received on account (ROA), paid on account (POA), balance due, balance forward, or previous balance are not acceptable forms of documentation and will be returned to you for insufficient information.

The more specific documentation you provide, the less chance of returned claims and/or delays in claim processing.

C. For DEPENDENT CARE, the required documentation must be a paid receipt showing the dates of service, who the care was provided for, amount(s) charged, name, address and Tax ID # (or social security number) of the provider, (this should be a 9 digit number).

3. Mail your completed claim form and documentation to:

SIEBA, LTD.
Group 996
111 Grant Ave, Ste 100
PO Box 5000
Endicott, NY 13761-5000

4. If you have any problems or questions regarding claims or account status call:

SIEBA, LTD at: (607) 786 - 3003 or (800) 252-4624 FAX: (607) 786-3437