

# HR Concepts, LLC

"Your Third Party Administrator of Choice"

## Section 125 Reimbursement/Claim Form

**Part. Employee Information** (  Please check if this is a new address)

Employee Name: _____	SS # _____	- _____	- _____	
Mailing Address: _____	City: _____	St.: _____	Zip: _____	
Street Address: _____	City: _____	St.: _____	Zip: _____	
Telephone: _____	Employer Name: _____	Plan Year: _____		

**Part II. Instructions for submitting form (Please read carefully)**

1. Fill out entire form, check whether the claim is for current plan year or previous plan year, and sign the bottom
2. Reimbursement is only for expenses that will not be reimbursed from any other source. These expenses must have been incurred within the plan year unless your plan allows claims to be incurred 75 days after the end of the plan year, check with your company or call HR Concepts. You have up to 90 days after the end of a plan year to submit expenses that are eligible for reimbursement.
3. All 3rd party documentation supporting your request for reimbursement must be attached. This supporting documentation must show date of service (Not the payment date), amount of expense that you are responsible for, who it was for, and a brief description of expense.
4. Dependent Care Reimbursement requests must have a signature from the provider as well as the tax ID # of the provider filled in below.
5. Dependent Care Reimbursements may be submitted in advance of future service dates. You will receive a reimbursement check from your account according to your payroll cycle. The amount you receive will be equal to your payroll deduction or account balance, whichever is greater. If the amount of the reimbursement check is going to exceed your actual expense for the said time frame, you are required to notify us so that we may adjust the claim.

**Part III. Healthcare FSA Claim Information**

**\*Please Check Appropriate Plan Year:**       Current Year's Claim     Previous Year's Claim

Name of Covered Person <small>(Self, Spouse, Dependent)</small>	Date of Service <small>(Not payment Date)</small>	Type of Service <small>(Medical, Dental, Vision, Dependent Care)</small>	Description of Services	Amount of Claim

**Total of Healthcare Claim: \$ \_\_\_\_\_**

**Part IV Dependent Care FSA Claim Information**

**\*Please Check Appropriate Plan Year:**       Current Year's Claim     Previous Year's Claim

Name of Provider	Date of Service <small>(Not payment Date)</small>	Type of Service <small>(Daycare/Baby Sitting/ Preschool/ Day Camp/Etc)</small>	Provider Signature & TAX ID # <small>(Have Provider Sign Here or Attach their Receipts)</small>	Amount of Claim

**Total of Dependent Care Claim: \$ \_\_\_\_\_**

**Part V Signature**

The above statements and submitted information for reimbursement are true. I am only submitting for reimbursement for expenses that I incurred for myself or legal dependents. I certify that I have not been nor will I be reimbursed for these submitted reimbursements from any other source. I further certify that I will not claim these expenses as a tax deduction.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Flex Plans • HSA's • Commuter Plans • HRA's • Dental Plans • COBRA

**Phone: (603) 647-1147 • Fax: (603) 647-2329 • email: info@HRConcepts.biz**  
**www.HRConcepts.biz • 9 Cedarwood Drive, Unit 8 • Bedford, NH 03110**