INSURANCE ADMINISTRATOR OF AMERICA, INC.

County of Monmouth 2010/2011 - Group #9992
Health Care Reimbursement Request Form

Please indicate the appropriate Account:
☐ Flexible Spending Health Account (FSA)

Employee Name: _____
Address: _____
_____
SS#: _____
Email: _____
Phone #: _____

☐ Check Box if this is a new address

Expenses eligible under this account are limited to incurred expenses (*services rendered*) only. No prepayment of services should be submitted until the service has been provided. Expenses reimbursed (*or reimbursable*) by any medical, dental or vision insurance **are not eligible.**

Please fill in all information requested and attach copies of receipts/statements of provided services to this form as evidence of services. Be sure to provide all information requested by this Form. If this form is incomplete, it will be returned to you.

Reimbursement Instructions:

The following information must be included on your receipt/statement in order to receive payment:

- Name of person receiving medical care
- A receipt from a third party provider that shows:
  1. The dates of actual services rendered
  2. Provider's name and address
  3. Nature of service provided or item purchased
  4. Cost of the services provided on those dates

Please Note:

*Canceled checks and credit card receipts will not be accepted.
*Proof of payment or notice of payment due will not be acceptable.
*Pharmacy receipts must state the name of the drug being prescribed and over-the-counter receipts must show the name of the actual drug purchased.

If you have any questions regarding an eligible or ineligible expense, please feel free to contact us.

MAIL or FAX Claim Form & Receipts to:
Insurance Administrator of America, Inc. P.O. Box 5082
Mt. Laurel, NJ 08054, FAX: (856)489-8051
E-Mail Claim Forms: FlexClaims@iaatpa.com

	EXAMPLE	Expense # 1	Expense # 2	Expense # 3	Expense # 4
Date Medical Service or Item Actually Provided	02/04/11				
Name of Person Receiving Medical Service and His/Her Relationship to You	Fred Jones ☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Type of Service Provided	Eyeglasses				
Proof of Expense Is Attached (including Name or type of Medicine or Drug)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Total Expense	$100				
Amount Paid or Reimbursed by Another Plan	$0				
Reimbursement Requested	$100				

Total Reimbursement Requested _____

I authorize the above expenses to be reimbursed from my Health Spending Account. To the best of my knowledge, my statements on this Form are true and complete. I certify all of the following: Either I, my Spouse or my Dependent has received the services described above on the dates indicated, or the expenses qualify as valid Medical Care Expenses under Code Section 213(d), as further defined in the Plan document (the "Plan"). I certify that all drugs were obtained legally in the United States. These expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other plan, and I will not seek reimbursement for them under the major medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g. a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

Employee Signature: _____ **Date:** _____
*(Employee Signature **must** be provided in order to process this form)*