Medical Expense Reimbursement Claim Form

Print Name: _____ Soc Sec No: XXX-XX-_____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Employer: _____

Benefit Distribution Codes

20	Medical	24	Non-Recurring Health Ins Premium
21	Pharmacy	25	Recurring Premiums Paid To Employer*
22	Vision	26	Recurring Premiums Paid To Employee*
23	Dental	*	Number of Months For Recurring Premiums, 12 Maximum _____

Note: Code 25 and 26 are to be used only to have payments of premiums set up on an ongoing basis.

The undersigned participant in the Health Savings Reimbursement Plan requests reimbursement in the amounts shown below. NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider, or the provider's signature) as well as proof that the claim is not being reimbursed by any other means, such as an Insurance Company. Also, you will not be entitled to claim this expense as a tax deduction.

Date Incurred	Name Of Service Provider	Signature Of Provider (No Receipt Needed)	Describe Expense / Benefit Description Code	Person For Whom Expense Incurred		Amount Claimed
					$	
					$	
					$	
					$	
					$	
					$	
					$	
					$	
					$	
			Total Amount Claimed (Minimum $200.00 for Non-Recurring Claims)		$	

REMINDER: Did you attach copies of your bills or receipts? Please allow up to 30 days for reimbursement.

READ CAREFULLY: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Health Savings Reimbursement Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Participant Signature: _____ Date: _____

_____ **Initial here if you retired after January 1, 2014.** By initialing this section, I certify I am no longer a current employee, whether full, part time or temporary, with the above named employer. I understand if I return to work for the employer, I am not eligible for reimbursement until after I have terminated from employment with the above named employer.

Mail, E-mail Or Fax Claim Form With Copies Of Your Bills Or Receipts To: PELION BENEFITS, INC. • 3713-C University Drive • Durham, NC 27707
claims@pelionbenefits.com • Fax 919.942.2804 • Telephone 888.532.7526

PELION BENEFITS

www.pelionbenefits.com
3713-C University Drive, Durham, NC 27707
Tel: 888-532-7526
Fax: 919-942-2804

ACH Direct Deposit Authorization Agreement

- For your security, and to assure an accurate transfer of funds, complete this entire form in a legible manner and attach a voided check where indicated below.
- The routing and account numbers on this form must be identical to the routing and account numbers on your voided check.
- The payer name on the voided check must match the plan participant's name.
- If a voided check is not available, or if the account number or routing number provided on this form is different than on the voided check, include a letter from the bank or financial institution on their letterhead. Have the letter signed by an authorized representative of the bank and indicate the name of the account holder and provide the routing and account numbers to be used by Pelion Benefits, Inc. for ACH purposes.

I hereby authorize Pelion Benefits, Inc. to initiate credit entries or such adjusting entries, either debit or credit which are necessary for corrections, to my checking or savings account indicated below and the financial institution named below to credit (or debit) the same to such account.

Financial Institution _____ Checking ☐ Savings ☐

Address: _____

City: _____ State: _____ Zip: _____

Routing Number: ☐☐☐☐☐☐☐☐☐ Account Number: _____

This authority is to remain in full force and effect until Pelion Benefits, Inc. has received written notification of its termination in such time and in such manner as to afford Pelion Benefits, Inc. a reasonable opportunity to act on it.

Print Name: _____ Social Security Number: XXX-XX- _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone:_____ E-mail _____

Signature: _____ Date: _____

ATTACH A VOIDED CHECK HERE