# SECTION 105/125 REIMBURSEMENT CLAIM FORM

**Do you participate in a FSA for Medical Reimbursement?**
**Check the applicable box**

- ❑ Automatically submit any eligible portion of this claim to the FSA for processing.
- ❑ **Do Not** Automatically Transfer any portion of this claim to the Section 125 Plan. Process Section 105 only.

**INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM WILL DELAY PROCESSING OF YOUR CLAIM. Complete all personal information. Indicate the type of expense (MED), the incurred date(s) of the expense, Provider name/Dependent information, and the dollar amount eligible for processing. Attach copies of documentation (Explanation of Benefits (EOB), etc.) that will prove the incurred date/service date (not paid date) and service type that is eligible. Please sign the claim form below, attach copies of appropriate documentation, and forward by fax OR mail (not both) for processing.**

Employer Name_____ Daytime Phone (____)_____

Employee Name _____Social Security Number *(last 4 digits required)* _____
Last First Middle Initial

Employee Address _____

☐ **Check if new address**

**Office Use Only**

| Category | Date Incurred | Dependent Name/Provider | $Amount | 105 $ to be paid | 125 $ to be paid | Office Use |
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Date Expenses are paid**:** _____

I certify that the above information is correct and that the expenses claimed were incurred by me, my spouse, or by my eligible dependents after my effective date of coverage in my employer's benefit plan. The submitted expenses are valid Qualified Medical Expenses as defined in the Plan Document. I further authorize any unpaid expenses above to be automatically filed with the Section 125 flexible spending plan, if I have elected to participate. I further certify that none of the expenses automatically filed in the Section 105 and/or 125 plan have been or will be reimbursed by any other source and that I have not and will not claim these expenses on my personal income tax return. I acknowledge that if my coverage under the Health Reimbursement Arrangement (HRA) and/or the Flexible Spending Account (FSA) does not constitute permitted non-HDHP coverage I am not eligible for Health Savings Account (HSA) contributions while covered under the HRA and/or FSA plan.

EMPLOYEE SIGNATURE _____ DATE _____

**BENEFITS DESIGN GROUP, INC. PO BOX 370 Onalaska, WI 54650 1-800-342-8235 or (608) 781-2159 FAX (608) 781-4576**
**SCAN and EMAIL to: bdggeneral@bdgflex.com**