"Limited Purpose"
Health Care Flexible Spending Account Claim Form

PLEASE PRINT

Name _____ Social Security #_____

Address_____ Employer_____

_____ Daytime Phone _____

☐ Please check box for change of address

Instructions for requesting reimbursement

- Complete this form, making sure that you sign and date below.
- Attach supporting documentation.
  - --- **Eligible expenses covered by vision, dental, or orthodontia must be submitted to all other plans under which the expense is eligible.** Then request reimbursement by submitting this form along with a copy of the Explanation of Benefits (EOB) form that shows the patient name, nature and amount of expense, date incurred, and certification of the amount of expense that is your responsibility.
  - --- **Eligible expenses NOT covered by vision or dental plans** may be submitted directly by completing this form and attaching supporting documentation. Documentation must show patient name, nature and amount of expense, date incurred, and provider of service (see back of form for examples of unacceptable documentation).
  - --- **Documentation will not be returned; therefore, it is recommended that you keep copies of your submissions.**

Payments will be made directly to you; they cannot be assigned to the provider of services.

Date expense was incurred	Amount to be Reimbursed	Name of Service Provider	Brief description of expense	Patient Name
Total				

I request payment of $_____ from my "Limited Purpose" Health Care Reimbursement Account for the above expenses. To the best of my knowledge, these expenses are eligible under the plan (see reverse side) and they are for myself or for an eligible dependent. I further certify that these expenses have not been reimbursed under any other health plan, and that I will not seek reimbursement under any such plan. I understand that any expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Signature_____ Date_____

Attach supporting documentation and return to:

Mail to: **LD&B Benefits Administrators**
205-C South Liberty Street
Harrisonburg, VA 22801

Fax to: **(866) 292-8331, (540) 438-4133**
Phone support: **(540) 437-1425**, **(877) 532-5478** M – F 8:00 – 5:00 EST
Secure upload at: **www.LDBbenefitsadmin.com**

Health Care Expenses

ELIGIBLE EXPENSES:

- Vision expenses including examinations, eyeglasses, contact lenses and solution
- Dental care including orthodontia

Expenses incurred by you, your spouse, or dependents (if you provide more than half of their support) that are not reimbursable from another source (i.e. insurance) and that are incurred while you are an active participant in the plan may be eligible for reimbursement.

Please note - Examples of unacceptable documentation are as follows:

- Credit card receipts or statements
- Cancelled checks
- Balance forward or balance due statements
- Payment on account receipts

Expenses must be incurred during the period of coverage for which you made your election while you are an active participant. Expenses are considered to be incurred on the date services are provided – not when the service or item is billed or paid for. Any balance in your account after the claim submission cut-off date for a plan year will be forfeited.

Expenses reimbursed from this plan are not eligible for the medical care tax deduction.