



Specializing in Benefit Administration

Select Data Service Administrators, Inc.

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Phone: 1-888-698-1429 FAX: 1-888.877-4747
View your account on-line at www.selectdataservice.com

Claim for Reimbursement

(Instructions on reverse side)

Please keep a copy for your records

CHECK IF ADDRESS CHANGE

SECTION I - PERSONAL INFORMATION

Form for Section I containing fields for Employer's Name, Your Name, Social Security Number, Mailing Address, Work Phone, Home Phone, City, State, and Zip.

SECTION II - DEPENDENT DAYCARE EXPENSE CLAIMS

Table for Section II with columns: Name of Dependent(s), Period Covered (From, To), Name, Address and Taxpayer Identification Number of Provider of Service, and Amount Incurred. Includes a total row for dependent care expense claims.

SECTION III - UNREIMBURSED MEDICAL EXPENSE CLAIMS - YOU, YOUR SPOUSE AND DEPENDENTS

Table for Section III with columns: Date Service Provided, Name of Service Provider, Service Description, Person for Whom Expense Incurred, and Net Amount After All Insurance Payments. Includes a total row for medical care expense claims.

SECTION IV - THIRD PARTY MEDICAL INSURANCE CLAIMS

Table for Section IV with columns: Dates of Coverage, Name of Service Provider, Expense Description, Person for Whom Expense Incurred, and Net Amount. Includes a total row for third party medical insurance claims.

SECTION V - CERTIFICATION

The undersigned participant in the Cafeteria Plan certifies that all expenses for which reimbursement is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses, and that these expenses have not previously been reimbursed and are not reimbursable under any other health plan coverage.

Employee's Signature

Date

Procedures for Submitting Claims

In order to receive reimbursements on your Cafeteria Plan, all claims should have the following information:

Section I:

1. Employee or participant's name, address, work and home telephone number
2. Employer's name
3. Employee's social security number
4. Employee's signature and date

The following information must be listed on **ALL RECEIPTS AND THE CLAIM FOR REIMBURSEMENT FORM:**

1. Date the service was provided
2. What service was provided.
3. Name of service provider
4. Person who received service
5. Net amount of service.

A provider's signature or receipt is required with your claim for reimbursement.

Section II: Dependent Day Care Expense

Dependent Child Care and Day Care expenses are listed in this section. List the Dependent's name, dates the services were provided, the name, address, and tax identification number of the provider of services and the amount of services. If the provider of service does not have a tax identification number, a social security number is acceptable. You **cannot** claim registration fees, activity fees ie., gymnastics, dance etc., or snack fees.

Section III: Unreimbursed Medical Expense

Medical Services for yourself, spouse, and dependents are listed in this section. Medical Services for example include physician visits, hospital visits, surgery, lab work, dental, optometry, and prescriptions.

Section IV: Third Party Medical Insurance

Cancer and Health premiums that are not payroll deducted through your or your spouse's employer are listed in this section. Canceled checks and bank statements are acceptable as receipts for Third Party Insurance Only.

The following are not allowable charges under Code Section 125 of the IRS:

1. Canceled Checks as receipts
2. Billings that list previous balance, balance forward, or paid on account
3. Amount paid by insurance
4. Prescriptions—**PONDIMIN, ADIPEX, PHENTERMINE, FASTIN, NICORETTE GUM, HABITROL, NICODERM, OBENIX, PROPECIA AND IONAMIN.** Unless they are medically necessary and a physician's letter is required. All prescription receipts must list the prescription name.
5. Services—**WEIGHT LOSS, STOP SMOKING (you may now count smoking cessation programs that are prescribed by a physician , over the counter programs are still not eligible), HOME IMPROVEMENTS, PLASTIC SURGERY, and DIET COUNSELING.** Unless they are medically necessary and a physician's letter is required.

Section V: Signature and Date

Sign and date your claim for reimbursement and mail to: Select Data Service Administrators
P.O. Box 2076
Batesville, AR 72503

If you have questions regarding how to complete your claim form please call 1-888-698-1429 or (870) 698-1429 and ask for Cafeteria Plan Administration. You may fax your claim to **(888) 877-4747** attention Cafeteria Plan Administration. If you fax your claim please **do not** send the original.