

## Form Completion Guide

### STEP 1: Participant Information

- Please write legibly. Missing information may delay the processing of your claim.
- **Email address:** If you enter your email address we will set up automatic email notifications. You do not need to provide it on this form again unless it has changed. Watch for emails from us and allow emails to pass through spam protection.

### STEP 2: Reimbursement Information

- **Plan Type Code:** Use the three/four-letter code below the grid to identify the account you desire reimbursement.
- **Indicate if you filed the claim on-line:** Yes or No
- **Date Expense incurred or Provided:** Provide a date or a range of dates
- **Product or Service Provider:** Give a short description of the service (ex. Dental, Rx, Dr. Jones, etc.)
- **Person Receiving Product/Service:** Indicate what family member is receiving the service
- **Claim Amount:** Provide the total requested amount from the documentation.
- **Dependent care accounts only:** Please provide the name of your dependent care provider, the provider's Tax ID (TIN) and the provider's signature. You are required to include the name, address, and TIN of the service provider on IRS Form 2441 that you must attach to your federal income tax return.
- **Total Reimbursement Requested:** Total your claims.

### STEP 3: Participant Certification

Sign and date the form after reading the Participant Certification. Your signature is required for reimbursement.

#### **Medical Reimbursement Account Documentation/Substantiation Guidelines**

Attach a copy of your insurance company's Explanation of Benefits (may be required for HRA accounts) or copies of receipts/bills if there is no insurance coverage to document the amounts. Documentation should include the date and type of service, name of service provider, and your final responsibility for service.

#### **Dependent Care Reimbursement Account Documentation/Substantiation Guidelines**

Attach a copy of your receipt or statement from the dependent care provider. Documentation should include the dependent care provider name, dates of service, dependent care provider Tax ID (TIN) and the claim amount. You are required to include the name, address, and TIN of the service provider on IRS Form 2441 that you must attach to your federal income tax return.

For additional information, please see your Plan's Summary Plan Description or call us toll-free at 1-866-451-3399.

## Form Submission Guide

### STEP 1: Gather supporting documentation/substantiation

### STEP 2: Determine the method that you prefer to submit your claim

1. Email to [customerservice@discoverybenefits.com](mailto:customerservice@discoverybenefits.com)
2. Fax toll free to 1-866-451-3245
3. Mail to PO Box 2926, Fargo, ND 58108-2926

### STEP 3: Submit both the Reimbursement Request Form and a **copy** of your substantiation

Discovery Benefits will process your claim promptly (two business days from receipt). If there are any concerns about your claim, you will be notified in writing.

**Would you like to receive your refund via free direct deposit?  
Direct deposit enrollment forms can be found on online at [discoverybenefits.com](http://discoverybenefits.com)**

# Reimbursement Request Form



## STEP 1 - Participant Information -- Missing information may delay the processing of your reimbursement.

Name  Employer

Social Security Number  Employee ID #

**Email Address – Changes Only**

## STEP 2 - Reimbursement Information

### Participant Address - Changes Only

Address

City

State/Zip

Would you like to receive your refund via direct deposit? Direct deposit enrollment forms can be found online at [discoverybenefits.com](http://discoverybenefits.com)

Plan Type*	Did you File Online? (Y or N)	Date(s) Expense Incurred or Range of Dates	Product/Service Provider Feel free to add all expenses for a Plan Type together as one claim	Person Receiving Product/Service	Claim Amount	Dependent Care Provider Tax-ID Number and Signature (Only required for DCA Claims)

\*Plan Types **Total Reimbursement Requested:**

**MSA-** Medical Spending Account; **DCA-** Dependent Care Account,  
**EMSA-** Employer Funded Medical Spending Account; **EDCA:** Employer Funded Dependent Care;  
**HRA-** Health Reimbursement Account; **TRN-** Transportation; **PRK-** Parking  
**RMSA-** Retiree Medical Savings/Spending Account  
**IPA-** Individual Premium Account

## STEP 3 - Participant Certification

To the best of my knowledge and belief my statements on this form are complete and true. I certify that the reimbursement requests I'm submitting are IRS eligible expenses for me or eligible dependents as defined by the IRS. I certify that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other source. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include that TIN on IRS Form 2441 that I must attach to my federal income tax return.

I understand that Discovery Benefits, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I authorize a deduction in my account in the amount of the reimbursement. I received for services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid expenses under the Plan. Transportation participants: I certify that I used the Transportation Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer noted above. BY SUBMITTING THIS FORM I CERTIFY THE ABOVE.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

For office use only: Plan Year 1 \_\_\_\_\_ Plan Year 2 \_\_\_\_\_