Select Data Service Administrators, Inc.
P.O. Box 45132, Jacksonville, Florida 32232-5132
Phone: (800) 434-8026 FAX: (904) 828-7878
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

Your Employer's Name		Your Name		
Your Social Security Number		Mailing Address (Include Number and Street)		
Work Phone ( )	Home Phone ( )	City	State	Zip

SECTION II - DEPENDENT DAYCARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered From	Period Covered To	Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
Provider Signature (Not necessary if submitting receipt)			TOTAL DEPENDENT CARE EXPENSE CLAIMS	

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

Date Service Provided	Name of Service Provider	Service Description	Person for Whom Expense Incurred	Net Amount After All Insurance Payments
Provider Signature (Not necessary if submitting receipt)		TOTAL MEDICAL CARE EXPENSE CLAIMS		

SECTION IV - THIRD PARTY MEDICAL INSURANCE CLAIMS

Dates of Coverage	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		TOTAL 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. 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, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all taxes on amounts paid from the Plan which relate to such expense. The undersigned also understands that he or she is responsible to keep sufficient documentation to substantiate the expenses claimed for reimbursement, as may be required by the IRS.

Employee's Signature ____________________ Date ____________________

CP125-REIM-W (8-04) 1 COPY - SDSA with receipts. 1 COPY - For your records

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 45132
Jacksonville, FL 32232-5132

If you have questions regarding how to complete your claim form please call 1-800-434-8026 and ask for Cafeteria Plan Administration. You may fax your claim to **(904) 828-7878** attention Cafeteria Plan Administration. If you fax your claim please **do not** send the original.

1 COPY-SDSA with receipts1 COPY-For Your Records