



**ARCHDIOCESE
OF PORTLAND
IN OREGON**

Health Care Spending Account Reimbursement Request Form

(Please see the reverse side for instructions in preparing and submitting this form)

Employer/Location Name & Address		
Employee Name (Last, First, M.I.)		Social Security Number
Address (Street, City, State, Zip)		Daytime Telephone

List expenses submitted for reimbursement (Please attach all supporting documentation).

Name		Relationship to Employee
Date of Service	Service Provider	Amount
FROM: TO:		\$

Name		Relationship to Employee
Date of Service	Service Provider	Amount
FROM: TO:		\$

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Date of Service	Service Provider	Amount
FROM: TO:		\$

TOTAL Reimbursement Amount: \$ _____

The Internal Revenue Code permits health care spending account reimbursements only for tax-deductible expenses. *A&I Benefit Plan Administrators, Inc.* is not liable to the participant or any other entity for taxes, interest, penalties or other consequences, which may be assessed by any taxing authority for disallowed expenses.

I request reimbursement for the attached expenses under the Health Care Spending Account Plan. I certify that my eligible dependents or I have received these services and that they are reimbursable under the terms of my employer's Health Care Spending program. Furthermore, I certify that I have not been nor will be reimbursed for these expenses from any other source.

Account Holder's Signature

Date

- We have made the Health Care Spending Account administration as simple as straightforward as possible, but we remind you of the following important points:
- You must use the Health Care Spending Account Reimbursement Request Form to request these dollars.
 - Health Care Spending Account dollars are paid to you. They may not be assigned to another person.

If you have any questions regarding your Health Care Spending Account, or how to complete this form, please call **(503) 222-7702 or (800) 811-8851**.

Submit signed, ORIGINAL Reimbursement Request Form to: **A&I Benefit Plan Administrators
1220 SW Morrison, Suite 300
Portland, OR 97205.**

INSTRUCTIONS

1. The expense must be for a health care (medical, dental or vision) service, covered medication, or other covered product received by you or one of your dependents.
2. The expense must be an expense that would have qualified for a tax deduction under the Internal Revenue Code.
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:
 - An itemized bill showing dates of service, provider's name, patient's name and amount for service.
 - Copy of any Explanation of Benefits statement from any insurance plan under which claimant is covered.

PLEASE NOTE: Balance forward statements and checks (copies of initial and/or canceled checks) are not acceptable.

4. Complete the Health Care Spending Account Reimbursement Request Form and submit along with your supporting documentation to:

A&I Benefit Plan Administrators
1220 SW Morrison, Suite 300
Portland, OR 97205.

Retain a copy of the Reimbursement Request Form and copy (ies) of supporting documents for your records, as those submitted cannot be returned.

5. All reimbursements will be paid by check and mailed to your home address.
6. If you have any questions, call A&I Benefits Plan Administrators at (503) 222-7702 or (800) 811-8851.