SECTION 125 CAFETERIA PLAN CLAIM FORM INSTRUCTION GUIDE

If you are missing information, your request for reimbursement will be denied or delayed. Please keep all of your original receipts and only send in copies of your receipts with your completed Claim Form. You are responsible for maintaining all original receipts and copies of your submitted Claim Forms in the event you are audited by the IRS. If you are claiming mileage expenses, please attach the "Mileage Claim Form" and include the amount claimed on THIS form.

Proper Documentation and Receipts

Medical Expense Receipts	Dependent Care Receipts	Unacceptable Documentation
•Date of service or purchase	•Date(s) of service	•Balance forward statements
•Description of service or item	•Dollar Amount of Service	•Statements only showing amount paid
•Insurance company EOB	•Name of Provider	•Credit card receipts or cancelled checks
•Dollar Amount (after insurance)	•Tax ID number for Provider	•Bills for pre-paid expenses that have not occurred

Important Submission Dates You Must Meet

Failure to meet these Plan Year submission dates can cause forfeiture of reimbursement or spending account values (use-it-or-lose-it rule).

►Routine Plan Year Submissions

If you are submitting paper claims, the claim must be received by Benefit Alternatives, Inc. no later than seven (7) business days before your pay day. Any submissions received after that time will be paid on the next pay period.

►Understanding the Plan Run-Out Period

The run-out period is a specified period of time after the end of the Plan Year during which you may continue to SUBMIT claims incurred during the Plan Year Period. This is not a time period where you can continue to incur new expenses, but rather, the run-out period allows you to gather and submit expenses before forfeitures are applied. You have a ninety (90) day run off period. Any claims incurred on or before the last day of the Plan Year must be received by Benefit Alternatives, Inc. on or before the ninetieth day. If we receive any claims past the ninety (90) day run-out period, they will not be paid.

What To Do If A Claim is Denied or Rejected

If you do have a claim rejected, you will receive the rejection notice at the home address you list on your claim form. Your notice will provide you the reasons for the denial or rejection.

- ► A **denia**l typically results from expenses that are not qualified under the Plan or which have not been submitted within the time frames established by the Plan.
- ► A **rejection** typically occurs when information is missing, difficult to read, or improperly documented.

Questions?

Our office is open from 9am – 5pm eastern standard time. We have listed your day-to-day contact in our office below. Please contact us with any questions you may have.

Shirley Schmuhl, Plan Analyst, (770) 993-8683 (voice) • (866) 323-2363 toll free • shirley@benefitalt.com (email)

SECTION 125 CAFETERIA PLAN CLAIM FORM (2020-2021) AGNES SCOTT COLLEGE

Plan Year = 7/1/2021 – 6/30/2022

Please carefully read *all* instructions before filing your claim for reimbursement. *=Required field.

*Employee Name (First, MI, Last) (PRINT)

*Social Security Number

*Mailing Address

Email Address

*City

*State

*Zip

( ) -

*Daytime Phone Extension

Once the Plan Year has ended, all receipts **must be received** by Benefit Alternatives, Inc. **no later than ninety (90) days** after the end of the Plan Year or you will FORFEIT any unused healthcare money in excess of $500.00.

Reimbursement Account Type		List First Date of Service (From)	List Last Date of Service (To)	Total Expenses Submitted
Health Care Expenses		____/____/____	____/____/____	$
Dependent Care Expenses	Day Care Provider Tax ID:_____	____/____/____	____/____/____	$
Have you previously filed for any of these same expenses with us using any other method? (ex - fax, on-line, mail, email) ❍Yes ❍No **Note: Receipts must be received 7 business days prior to your pay day. Any receipts received after that time will go on the next check run. We do not return receipts.**			**Total Submitted:**	$

READ THE FOLLOWING VERY CAREFULLY:

I certify by signing below that all expenses for which reimbursement is requested were incurred during the Plan Year in which I am applying for reimbursement and have not been reimbursed or are not reimbursable under any other health plan coverage. I understand that I alone am responsible for the accuracy and veracity of all information relating to this claim and unless an expense for which reimbursement is made is a proper expense under the Plan, I may be liable for payment for all related taxes and penalties including Federal, State, and FICA on amounts paid from the Plan which relates to such expense or expenses. If I have submitted a claim by fax, I will NOT mail the same claim. I also give Benefit Alternatives, Inc. permission to use any information submitted to process my claim.

_____ _____

Employee Signature Date

INCLUDE COPIES OF THIS CLAIM FORM AND ALL RECEIPTS IN YOUR SUBMISSION

MAIL to: Benefit Alternatives, Inc. • S-125 Claims Department • 902 Macy Drive • Roswell, GA 30076

FAX to: (770) 587-1678 or (770) 640-6938 • Email to: claims@benefitalt.com

On-Line Account Access: www.retirementlogin.com/benefitalternatives

Need help? Just call: (770) 993-8683 local • (866) 323-2363 toll free