Please staple all documentation to the back of this form.

Flexible Benefits and/or HRA Program Request for Reimbursement

This is a 2 page form. Please review TAB 2

EMPLOYER NAME: CHEMUNG COUNTY GOVERNMENT - GROUP 997

Please include an email address and/or phone number that we may contact you at if we have any questions regarding this claim.

( )_____-_____ and/or_____@_____

1 EMPLOYEE INFORMATION

Check here if this is a new address [ ]

Employee Name

Street Address

City, State, ZIP

SS# or ID #

2 CLAIM INFORMATION (see back side of this form for instructions)

This form must be filled out completely. Forms marked "see attached" may delay processing.

The plan will reimburse you the maximum amount you are eligible for. Please inform us if you are specifically requesting a lesser amount.

Circle Account	Provider of Service	Patient	Date(s) of Service	Amount to be Reimbursed	S=Substantiate O= Offset N = New Claim	Office use Only
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						
FLEX HRA Dependent Care						

* FLEX /HRA means - Medical/Dental/Vision * Dependent Care means - Day Care/Child Care

3 SIGNATURE

I request payment from my Flexible Benefits Account and/or HRA for the expenses itemized above. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I also certify that the total dependent care expense(s) (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that I have met all the requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature Date

FLEXIBLE BENEFIT CLAIMS PROCEDURE

1- Complete a claim form with EVERY submission. BE SURE ALL INFORMATION IS COMPLETE.

2- STAPLED to the claim form should be legible copies of documentation to supplor your request for reimbursement.

THIS DOCUMENTATION MAY INCLUDE, BUT IS NOT LIMITED TO:

A- Explanation of benefits form all medical/dental/vision benefit carriers.

B- Copies of walkout statements noting co-pay amounts, bills, or itemized RX receipts. (Cash register receipts are acceptable for Over the Counter "OTC" products only)
THIS DOCUMENTATION MUST BE ITEMIZED AND SHOULD INCLUDE:

* Name of provider of service
* Address of provider
* Patient's name
* Date of service
* Type of service (i.e. "office visit, "x-ray", etc)
* Charged amount for each service provided
* Medical/dental/vision benefit payments towards each charge and each date of servcie if applicable

Statements showing ONLY received on account (ROA), paid on account (POA), balance forward, or previous balances are not acceptable forms of documentation and will be returned to you as insufficient information.
The more specific documentation you provide, the less chance of returned claims or delays in claim processing.

C- For DEPENDENT CARE, the required documentation must be a paid receipt showing the dates of service, who the care was provided for, amount(s) charged, name, address and TAX ID# (or SSN) of the provider - this will be a 9 digit number.

3- If you used your WEX HEALTH Card for an expense that you have attached to this form, you may not be reimbursed a second time for the same expense. If you are using the expense attached to this form to offset or substantiate a debit card transaction, please indicate that on the front of this form.

4- This Plan has established a $25 minimum claim reimbursement amount unless your account balance is less than $25. If no other claims are submitted by the end of the Plan Year, this claim will then be processed.

5- Your Plan processes claims every other Monday of the month. Submit your claim no later than 12:00 NOON on the preceeding Thursday in order to be considered for that claim run. Please refer to the claim processing schedule you received with your initial EOB for specific dates and exceptions.

6- Mail-FAX-UPLOAD your claims as follows:
Mail to SIEBA, LTD. PO BOX 5000. ENDICOTT, NY 13761-5000
FAX to (607) 786-3437
UPLOAD from securly through our website portal at www.sieba.com

7- If you have any questions regarding your claims or account status, please call (607) 786-3003.