Group Dynamic Inc.

REIMBURSEMENT REQUEST for Flexible Spending Accounts

(Please staple receipts to back of form)

LP

EMPLOYEE INFORMATION	
Employee Name:	SS #
Employer:	Plan Year:

DEPENDENT CARE (Child Care, Elder Care)

Provider Name	Provider SS# or Tax ID#	Services For (Name)	Relationship/Age	Date(s) of Service	Amount
				TOTAL:	

DEPENDENT CARE PROVIDER (If you don't have a receipt, this section must be completed)

Provider's Name _____ Provider SS/Tax ID#: _____

Provider's Address _____

Address City State Zip

I certify that I have provided the services as listed above.

_____

Provider's Signature Date

VISION, DENTAL, & PREVENTIVE CARE EXPENSES ONLY

Please note: As a participant in a Health Savings Account program, you are only eligible to be reimbursed for qualified vision, dental, and/or preventive care expenses until you have incurred the minimum statutory deductible.

Provider Name	Service/Item Purchased	Services For (Name/Relationship)	Date(s) of Service	Amount
			TOTAL:	

GENERAL MEDICAL EXPENSES (Eligible for reimbursement only after statutory deductible has been met)

☐ **I have attached documentation from my health insurance provider indicating that I have met the minimum statutory deductible. NOTE: IRS regulations prohibit reimbursement of otherwise eligible medical expenses until this deductible limit has been met.**

Provider Name	Service/Item Purchased	Services For (Name/Relationship)	Date(s) of Service	Amount
Mileage Reminder	Reimbursement for mileage to/from an eligibile medical appointment		# miles x 0.23/mile	
			TOTAL:	

I request reimbursement for my dependent care expenses and/or medical care as itemized above. Enclosed are receipts which state: date of service, provider name, type of service, and fee charged for the service. My signature below acknowledges my understanding of the following: 1.) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source. 2.) The expenses must qualify for reimbursement under the Internal Revenue Code. 3.) Reimbursed expenses cannot be claimed as credits or deductions on my personal income tax. 4.) I have retained copies of the documentation submitted with this claim as these materials will not be returned to me.

SIGNATURE REQUIRED: **Date:**

Reimbursement requests must be received before 12 Noon (ET) on Tuesdays for processing that week. Requests received after this time will be processed the following week.

MAIL TO: Group Dynamic, Inc., Reimbursement Benefits, 411 U.S. Route One, Falmouth, ME 04105

EMAIL TO: claims@gdynamic.com WEBSITE: www.gdynamic.com

FAX TO: **Reimbursement Benefits, 207-781-3841** **PHONE: (207) 781-8800 or 1-800-626-3539 (US)** **01-01-2012**