Please attach the required documentation to this form and send to:
(See back of form for explanation of required documentation)
Stanley, Hunt, DuPree & Rhine, Inc.
Post Office Box 6400
Greenville, SC 29606 OR
Fax number 1-252-293-9048 or 252-293-9049 **Number of pages in this fax _____**

OPTIONS FOR OBTAINING ACCOUNT INFORMATION:
website www.shdr.com (pin# required) Interactive Voice Response 1-800-413-6706
1-800-930-2441 or 1-800-768-4873 1-864-527-0785 (Monday thru Friday 8:00 a.m.–6:00 p.m. ET)

Employer _____

Flexible Spending Account Reimbursement Claim Form

Employee Name: **Social Security Number:**

Daytime Phone Number: **E-Mail:**

Health Care Expenses

☐ **(1) I have insurance for this expense.** Attach a copy of the Explanation of Benefits (EOB) statement that you received from your insurance carrier showing how benefits were paid. ***IMPORTANT NOTE: IF YOU HAVE GROUP INSURANCE COVERAGE BUT DO NOT SUBMIT AN EOB OR AN ITEMIZED STATEMENT SHOWING THE PORTION PAID BY INSURANCE YOUR CLAIM WILL BE DENIED.*** **If the documentation provided clearly shows that the expense is for a co-pay, an EOB is not required.**

☐ **(2) I do NOT have insurance coverage for this expense.** Submit an itemized statement showing the date of service, provider's name, patient name, services provided and the amount of the charge.

Provider of Service	For the benefit of (Name)	Relationship	Date Expenses Incurred	*Expense Type	Reimbursement Request Amount
					$
					$
					$

***Expense Type Code: **D**-Dental **H**-Hearing **V**-Vision **P**-Prescription **M**-Misc/Medical **O**-Orthodontia
To add more claims please see back of form

Total Health Care Reimbursement Requested $_____(A)

Dependent Care Expenses

Provider of Service And Tax ID or SSN	Dependent Name And Age	Relationship	Date Expenses Incurred	Reimbursement Request Amount
				$
				$
				$

Total Dependent Care Reimbursement Requested $_____(B)

TOTAL REIMBURSEMENT REQUESTED $_____(A+B)

I certify that the charges listed for dependent day care services have been incurred for the dates shown.

_____ _____ _____
Signature of Provider **Date** **Tax ID #/SS#**

Where I have not included the taxpayer identification number or social security number of each dependent day care provider listed above, I have done so because of one of the following reasons: The provider is a non-profit religious, charitable or educational organization [under Code Section 501(c) (3)]; **or**, I was unable to obtain this information after diligently trying to obtain it.

Employee Signature_____ Date_____

Employee Certification

1. The health care expenses claimed above are not eligible for reimbursement by any insurance carrier or employer sponsored plan.
2. The dependent care expenses claimed above are employment-related, have not been paid to a dependent, and are not greater than either my earned income or my spouse's earned income.
3. The expenses claimed above have not been and will not be taken as a credit or deduction on my personal income tax return.

Employee Signature_____ Date_____

Claims cannot be processed without the participant's signature.
See back for instructions on completing this form.

Instructions and Important Information Regarding Reimbursements

For information regarding Eligible and Ineligible Expenses under the Health Care and Dependent Care Reimbursement Accounts, please refer to your enrollment materials or visit the IRS at www.irs.gov

Health Care Expenses

There are two boxes on the front of this form describing the type of claim(s) you are submitting. Please mark the box or boxes that apply. Below is the documentation required for each type of claim:

(1) I have insurance for this expense.

If you have insurance coverage, a complete copy of an Explanation of Benefits (EOB) or a complete itemized statement from the provider showing the portion paid by insurance must be included. The EOB or itemized statement must include:

- The Date of Service
- Description of Services Provided
- Total Amount of Charges
- Patient Name
- Amount Covered by Insurance
- Patient Responsibility Amount

(2) I do NOT have insurance coverage for this expense.

If the expense is not covered by insurance, an itemized receipt must be submitted. The receipt must contain:

- The Date of Service
- The Name and Address of the Provider
- Patient Name
- The Services Provided
- The Cost

Please note the following items are **NOT** acceptable forms of documentation:

- Credit Card Receipts
- Check Copies
- Balance Due or Balance Forward Statements
- Paid on Account Statements

Dependent Care Expenses

- For reimbursement of Dependent Care Expenses, you must have your Day Care Provider sign and date the authorization on the previous page.

OR

- You may submit an itemized receipt containing the Date of Service, Provider Name, Tax Identification Number, Address of Provider, Dependent Name, and Cost.

Please retain copies of all items submitted for your records.

Total Health Care total from front of form $ (A)

Provider of Service	For the benefit of (Name)	Relationship	Date Expenses Incurred	*Expense Type	Reimbursement Request Amount
					$
					$
					$
					$
					$
					$

Expense Type Code: **D**-Dental **H**-Hearing **V**-Vision **P**-Prescription **M**-Misc/Medical **O**-Orthodontia **Total Health Care**

Reimbursement Requested $_____(A)