Mail to: **SOUTHERN ADMINISTRATORS AND BENEFIT CONSULTANTS, INC.**

SABC CLAIMS (601) 856-9933 WWW.SABCFLEX.COM Fax: (601) 856-8088

P.O. BOX 2449
MADISON, MS 39130-2449

REQUEST FOR REIMBURSEMENT

(Please print all required spaces (*) and sign).

*** Plan Year:** ______________________ **thru** ________________________

(Submit separate request forms for each Plan Year.)

*** COMPANY NAME:** ____

*** EMPLOYEE NAME:** ____ *** SSN:** ________________________

*** DAY TIME PHONE #:** (__________) _______________ **EMAIL ADDRESS:** ____________________________

DEPENDENT DAY CARE EXPENSES TOTAL: $____________________

UNREIMBURSED MEDICAL EXPENSES TOTAL: $____________________ *

TO PICKUP REIMBURSMENT at SABC,
PLEASE INSTRUCT IN BOX ABOVE.

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred after the effective date of my participation in the plan and only for eligible family members. I certify that these expense(s) have not been previously reimbursed or are not reimbursable under any other health plan coverage, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account be reduced by the amount of eligible expenses requested.

*** EMPLOYEE'S SIGNATURE:** ____ DATE: ____________________

DO NOT WRITE BELOW LINE **Ineligible Reason**

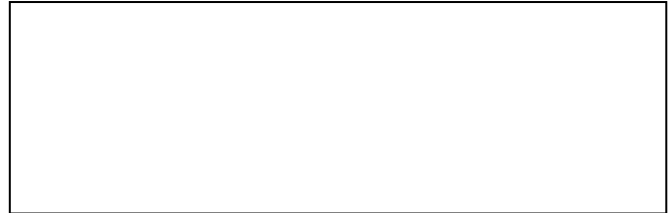
Date Incurred: Month: ____________________ Year: ____________________

DC Total: ____________________ DC Ineligible: ____________________

URM Total: ____________________ URM Ineligible: ____________________

PRM Total: ____________________ PRM Ineligible: ____________________

Process By: __________ Input By: __________



SABC CLAIM FORM INSTRUCTIONS

COMPLETEING THE CLAIM FORM:
Please complete the front of this form in its entirety. Incomplete forms will delay the processing of your request. All documentation is electronically scanned and must originate from a third party provider. Documentation, such as small pharmacy stub receipts, should be copied on a regular size sheet of paper. Multiple receipts may be copied on one page, or a printout may be requested from your pharmacy. Please do not use staples or tape.

FILING FOR DIFFERENT PLAN YEARS:
All expenses must have INCURRED, (date services provided, **not paid**) within your Employer's Plan Year, unless your plan offers an extended URM Plan. Total all receipts attached, and write the total amount in the appropriate space. Do not complete separate forms for each receipt, statements, and/or insurance explanation of benefits, ONLY for separate Plan Years. Expenses filed for Unreimbursed Medical, incurred for plans with a 2 ½ month extension that were incurred during the extension, will first be paid from the previous year, and then any remainder would be paid from the new Plan Year.

DEPENDENT CARE (DC):
All DC receipts must have the following information: Care providers' tax identification number or social security number, child(ren) name, date of birth and/or age, (under the age of 13) amount of expense and date of service, not date paid. Note: Book, activity fees and meals not included in tuition, may not be reimbursed. Day camps for care are eligible, overnight camps are <u>NOT REIMBURSEABLE</u>.

UNREIMBURSED MEDICAL (URM):
All URM receipts must have the following information:
A medical provider's name & address, date of service (not date paid), type of service/expense and cost of expense(s). All <u>Medical expenses must have patients name</u>. A statement with a Balance Forward or Previous Balance does not describe the type of services provided, and <u>are NOT REIMBURSABLE</u>. Explanation of Benefits "EOB" is a preferred receipt and in some cases, may be required.

Prescription drugs must include **patients name**, **name of the drug**, RX number and cost. Cash register receipts <u>that do not have the patient name are NOT Eligible</u>.

(**Cancelled Checks** are not accepted). Only <u>eligible</u> expenses, not reimbursable by insurance and/or any other third party, are reimbursable through URM.

OVER-THE-COUNTER-DRUGS:
Over-the-counter "OTC" drugs/medicines are NOT ELIGIBLE for reimbursement, without a prescription from your physician. Some OTC items, (Ex: contact lens solution) may be eligible. Please check the allowable expense located on our web site.

REIMBURSMENTS:
Mailed, Emailed and Faxed claims are processed daily. Reimbursements will be made once the claim exceeds the $15.00 check minimum (This does note apply to Direct Deposits). Final claims less than $15.00 and more than $1.00 will be reimbursed at the end of the plan year.

Reimbursements may be "Walked In" to our office, up to 4:00 PM each business day. Claims received after 4:00 PM will be processed the next business day.

Faxed & Emailed claims received by 2:00 PM are processed the same day. Faxed claims received after 2:00 PM will be processed on the next business day.

***WWW.SABCFLEX.COM*:**
Log on to our web-site for reimbursement forms and other information. You may obtain your current balance by entering your social security number as your employee number and your six digit date of birth as your password.