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

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

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

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/EMP ID**: _____

*** 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

Date Incurred: Month: _____ Year: _____

DC Total: _____ DC Ineligible: _____

URM Total: _____ URM Ineligible: _____

Process By: _____ Input By: _____

Ineligible Reason

Please see reverse side for more claim information.

SABC CLAIM FORM INSTRUCTIONS

COMPLETING 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 pharmacy, should be copied on a regular size sheet of paper. Multiple receipts may be copied on to one page, or a printout may be requested from your pharmacy. Please do not use staples or tape.

FILING FOR DIFFERENT PLAN YEARS:
Expense(s) that incur in separate Plan Years must be accompanied by a separate request form. All expenses must have INCURRED (date services provided, not paid) within your Plan's Benefit Period. 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.

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, (must be 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. Overnight camp is NOT REIMBURSABLE.

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 Medical expenses must have patients name. A statement with a Balance Forward or Previous Balance does not describe the type of services that are provided, and therefore, NOT REIMBURSABLE. Explanation of Benefits 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. Note: (Cancelled checks are not accepted). Only eligible expenses, not reimbursable by insurance and/or any other third party are reimbursable through URM.

WWW.SABCFLEX.COM:
Log on to our web-site to access our **Customer Portal** for electronic submissions, forms, current balances and other information 24/7.

For your convenience, SABC also offers our **Mobile App**. Login to our website for download instructions.
www.sabcflex.com

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