Flexible Spending Plan Reimbursement Voucher

Please read the back of this form for instructions on how to complete this voucher

BROOME-TIOGA BOCES PLAN YEAR 10/1/15-9/30/16

EMPLOYER / GROUP NAME

YOUR NAME S.S. NUMBER (Last 4 Digits)

YOUR ADDRESS CITY STATE ZIP

D Please check this box if this is a change of address.

To ensure you receive notification of claim(s) status, please update your Email address in the Benefits Portal at www.ThePreferredGroup.com .

Unreimbursed Medical Expenses

Receipts must include description of service, date of service, and amount.

Nature of Service	Date(s)	Amount
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
	TOTAL	$

Dependent/Child Care Expenses

Submit receipt including date of service, amount, and SS# or Tax ID# OR have provider fill out and sign below

Name of Day Care Provider	Signature of Provider	SSN / Tax ID

Name of Dependent	Age	Disabled
		Yes D No D
		Yes D No D
		Yes D No D

Description of Service	Date(s)	Amount
1		
2		$
3		$
4		$
	TOTAL	$

Premium Expenses

(Privately held insurance policies)

Type of Insurance	Dates of Coverage	Amount
1		$
2		$
	Total	$

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for re-crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

SIGNATURE Date

Send completed vouchers to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(518) 591-4960 (866) 989-8995
Fax: (518) 641-0325
www.ThePreferredGroup.com

Minimum Request:$25.00

++SEE REVERSE FOR DETAILS

* HOW TO COMPLETE YOUR REIMBURSEMENT VOUCHER *

FILLING OUT YOUR REIMBURSEMENT VOUCHER:

- Fill out your employer's name, your name and your address. The address on the voucher is the address to which your check will be sent. Please be sure to update your e-mail and mailing address at our website. Having the most current information will allow us to more rapidly notify you of your claim status, and enable you to receive your reimbursement faster. If you do not have access to the web, be sure to check the "Change of Address" box on the front of this form.
- Be sure to fill in the last 4 digits of your Social Security Number and your home and work telephone numbers.
- Sign and date your voucher. Your claim cannot be processed without your signature.
- Please provide a specific description of your expenditures under the "description" column.
- Fill out the total amount of your claim in each category: Medical and Dependent Care.

SUBMITTING YOUR CLAIMS FOR REIMBURSEMENT:

- Please be sure that the claims that you are submitting for reimbursement are allowable expenses. There are some specific expenses that are not allowed under various Flex plans. For example, cosmetic procedures, child care while one spouse is at home, and premiums for group-term life insurance are not reimbursable expenses.
- You will need to attach copies of third-party invoice(s) to substantiate your claim. These may include receipts, insurance Explanation of Benefits (EOB) or other documentation. Canceled checks cannot be accepted as proof of a reimbursable expense. Each invoice must contain the following information:
- Date of Service. Reimbursement is made based on date of service, not on date of payment.
- Nature of Service. Receipts must specify the nature of service so that we may determine its eligibility under the Flex plan.
- Individual Receiving Service. Only plan participants and their dependents may be eligible for Flex benefits.
- Amount of Service. Please provide documentation indicating the cost of services for which you are responsible.

++UNREIMBURSED MEDICAL EXPENSES:

- Certain UNREIMBURSED MEDICAL EXPENSES may require a prescription from a licensed physician indicating the medical necessity, and condition, for which the items are required. A new prescription is required for each condition, and for continuing conditions at the beginning of each plan year.
- Certain FDA approved Over-the-Counter drugs and medicines which are used to treat an illness or injury may be reimbursed with a third-party receipt showing the printed date of purchase, description, dollar amount and name of provider.
- Expenses covered by your insurance can only be submitted to PGP after they have been submitted to your insurance carrier. When you receive your Explanation of Benefits, submit the unpaid balance to PGP. We cannot reimburse you before we know how much of your claim will be covered by your insurance carrier.
- Expenses not covered by your insurance should be submitted along with a statement from either you or your insurance carrier indicating that the expenses will not be reimbursed.

DEPENDENT DAY CARE

- For DEPENDENT DAY CARE claims please list your provider's name and either Social Security or Tax ID number.
- If no receipt is provided, please have your daycare provider complete the dependent day care section of this voucher and sign at the signature line.*
- You can submit vouchers at any time, but you will only be reimbursed up to the amount that is in your Dependent Day Care Account at the time your voucher is received. The balance of the claim will be paid automatically as money is deposited in your account.

SUBMITTING YOUR CLAIM ONLINE:
Log In to : www.ThePreferredGroup.com
Click on "View/Create Messages"
Then "Compose New Message"
In the "TO" box select "submit claims" and click on "Insert Checked Contacts"
"Browse" to find your document(s).
"Add" your document(s) including your completed voucher.
Be sure the paperclip appears showing that your documents have been attached BEFORE you hit "Send"
Click on "Send"

If you have any questions regarding your Flex Account, please contact
The Preferred Group at (518) 591-4960 or (866) 989-8995
from 8 AM to 5 PM Monday through Friday.