ALERUS

# REIMBURSEMENT FORM

## FLEX/HRA OR PARKING/TRANSIT

| Employer | Name | Social Security No. | Email Address |
|---|---|---|---|
| | | | |
| Address (Street, City, State, ZIP) | | | ☐ Check if new address |
| | | | |

## HEALTH, LIMITED PURPOSE FLEXIBLE SPENDING, OR HRA ACCOUNT

| Name of Family Member | Amount of Expense | Description of Expense | Dates of Expense | Name of Provider[1] |
|---|---|---|---|---|
| | $ | | to | |
| | $ | | to | |
| | $ | | to | |
| | $ | | to | |
| **Total Requested** | $ | **Important:** Please attach itemized documentation to support all expenses claimed. Claims without documentation will not be paid. For HRA claims only, you must include the Explanation of Benefits from your insurance carrier. | | |

[1] Clinic, Pharmacy, Dentist, etc.

## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

| Dependent Name | Age | Amount of Expense | Provider Name | Provider Tax ID | Dates of Expense |
|---|---|---|---|---|---|
| | | $ | | | to |
| | | $ | | | to |
| | | $ | | | to |
| **Total Requested** | | $ | **Provider Signature[2]** | | |

[2] Provider signature may be provided in lieu of a receipt.

## PARKING/TRANSIT ACCOUNT

| Name of Provider[3] | Amount of Expense | Coverage Dates | Parking or Transportation (List one.) |
|---|---|---|---|
| | $ | to | |
| | $ | to | |
| | $ | to | |
| **Total Requested** | $ | | |

[3] Parking facility, metro pass, etc.

## INDIVIDUAL PREMIUM REIMBURSEMENT (FOR ICHRA/EBHRA BENEFITS ONLY)

| Policy for (self, spouse, family) | Amount of Premium | Dates of Expense | Name of Carrier |
|---|---|---|---|
| | $ | to | |
| | $ | to | |
| | $ | to | |
| | $ | to | |
| **Total Requested** | $ | **Important:** Please attach proof of premium cost incurred such as a copy of your itemized bill or contract from the insurance carrier. Copies of checks are not considered acceptable proof of an expense. | |

****NOT ALL BENEFITS MAY BE PROVIDED BY YOUR EMPLOYER****

I certify that the information contained in this form is to the best of my knowledge true and correct, and each item of expense is eligible for reimbursement. I also certify that all items requested to be reimbursed comply with the Company's Flexible Spending Account plan and such items have not and will not be reimbursed by any other plan or program. I certify that such items will not be deducted or taken as tax credits on my personal Federal or State Income tax returns for any year. I also understand if I receive money from my Flexible Spending Account for expenses that are not eligible, I may be liable for FICA, Federal, and State Income taxes on those amounts.

Employee Signature _____ Date _____

Return this form to: **Alerus, Attn: Health Benefits Department,** P.O. Box 64535, St. Paul, MN 55164-0535 | **Phone:** 877.661.4727
**Fax:** 507.373.2409 | **Web:** alerusrb.com | **DO NOT complete this form for Alerus Health Benefit card purchases.**