

# ALERUS

## REIMBURSEMENT FORM FSA OR HRA

Employer	Name	Social Security No.	Email Address
Address (Street, City, State, ZIP)			<input type="checkbox"/> 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 <sup>1</sup>
	\$		to	
	\$		to	
	\$		to	
	\$		to	
<b>Total Requested</b>	\$	<b>Important:</b> 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.		

<sup>1</sup> 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
<b>Total Requested</b>		\$	<b>Provider Signature<sup>2</sup></b>		

<sup>2</sup> Provider signature may be provided in lieu of a receipt.

### 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	
<b>Total Requested</b>	\$	<b>Important:</b> 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 Retirement and Benefits**  
**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 purchases made with your Alerus Health Benefits card.**