ALERUS

REIMBURSEMENT FORM

LIMITED PURPOSE FSA

Employer	Name	Social Security No.	Email Address

Address (Street, City, State, ZIP)	☐ Check if new address

LIMITED PURPOSE FLEXIBLE SPENDING

Name of Family Member	Amount of Expense	Description of Expense	Dates of Expense (From | To)		Name of Provider*
	$				
	$				
	$				
	$				
	$				
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.			

*Clinic, Dentist, etc.

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 purchases made with your Alerus Health Benefits card.