Reimbursement Request Form

Discovery Benefits
simplify.™

Form Completion Guide

STEP 1: Participant Information

- Please write legibly. Missing information may delay the processing of your claim.
- **Email address:** If you enter your email address we will set up automatic email notifications. You do not need to provide it on this form again unless it has changed. Watch for emails from us and allow emails to pass through spam protection.

STEP 2: Reimbursement Information

- Choose the plan year and indicate if you filed the claim online.
- **Plan Type Code:** Use the three-letter code below the grid to identify the account you desire reimbursement.
- **Date Expense Occurred or Provided:** Provide a date or a range of dates
- **Product or Service Provider:** Give a short description of the service (ex. Dental, Rx, Dr. Jones, etc.)
- **Person Receiving Product/Service:** Indicate what family member is receiving the service
- **Claim Amount:** Provide the total requested amount from the documentation. Review your Summary Plan Description, Employee Guide, and read the guidelines and certification sections on this form.
- *Dependent care accounts only:* **Dependent Care Provider Name and Tax ID Number:** Please provide the name of your Dependent Care Provider and their Tax ID Number on all claims.
- **Total Reimbursement Requested:** Total your claims.

STEP 3: Participant Certification

Sign and date the form after reading the Participant Certification. Your signature is required for reimbursement.

Documentation/Substantiation Guidelines

For medical reimbursements, please attach a copy of your insurance company's Explanation of Benefits (may be required for HRA accounts) or copies of receipts/bills if there is no insurance coverage to document the amounts. For Medical Spending Accounts, documentation should include the date and type of service, name of service provider, and the final responsibility for service. For additional information, please see the Summary Plan Description or call us toll-free at 1-866-451-3399.

Form Submission Guide

STEP 1: Gather supporting documentation/substantiation

STEP 2: Determine the method that you prefer to submit your claim

1. Fax toll free to 1-866-451-3245
2. Mail to PO Box 2926, Fargo, ND 58108-2926

STEP 3: Submit both the Reimbursement Request Form and a **copy** of your substantiation

Discovery Benefits will process your claim promptly (two business days from receipt). If there are any concerns about your claim, you will be notified in writing.

Reimbursement Request Form

Discovery Benefits
simplify™

STEP 1 - Participant Information -- Missing information may delay the processing of your reimbursement.

Name | Employer

Social Security Number | Employee ID #

Email Address – Changes Only

STEP 2 - Reimbursement Information

Did you file this claim online? ☐ **Yes** ☐ **No**

Participant Address - Changes Only

Address

City

State/Zip

Would you like to receive your refund via direct deposit? Direct deposit enrollment forms can be found on online at discoverybenefits.com

Do you need more room? File your claim online at discoverybenefits.com

Plan Type*	Date(s) Expense Incurred or range of dates	Product/Service Provider *Feel free to add all expenses for a Plan Type together as one claim*	Person Receiving Product/Service	Claim Amount	Dependent Care Provider Name and Tax ID Number

***Plan Types:**
MSA – Medical Spending Account; **DCA** – Dependent Care Account;
EMSA – Employer Funded Medical Spending Account; **EDCA** – Employer Funded Dependent Care;
HRA - Health Reimbursement Account; **TRN –** Transportation; **PAR** – Parking
LMSA – Limited Medical Spending Account
RMSA – Retiree Medical Savings/Spending Account

Total Reimbursement Requested:

STEP 3 - Participant Certification

To the best of my knowledge and belief, my statements in this form are complete and true. I certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other source. I also understand that Discovery Benefits, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I authorize a deduction in my account in the amount of the reimbursement. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid expenses under the Plan. Transportation participants: I certify that I used the Transportation Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer noted above.

Participant Signature **Date**

For office use only: Plan Year 1 _____ Plan Year 2 _____