



**Flexible Spending Account  
Reimbursement Request Form**

FAX: (603) 232-1854 (Max of 15 pages)  
Address: PO Box 1300, Manchester, NH 03105-1300  
E-Mail: hvdflex@benstrat.com

Employee Name:  
(First, Last)

Harvard University ID#

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Primary Phone:

Employer: HARVARD UNIVERSITY

E-mail:

**E-mail is required to receive important account notifications.**

Fill out form completely, including signature, and fax, mail or send via secure email to Benefit Strategies at the address listed above. Incomplete and unsigned claims will be returned. Please limit the number of pages faxed to a maximum of 15 pages. Reimbursement requests should be for a minimum of \$25 (unless using remaining account balance). Notifications will be sent via e-mail for claim confirmation, payment notification and denial letters. Payments will be sent to address on record. Claims will be applied to the earliest eligible plan year.

**Health Care Reimbursement Expenses**

Amount to be Reimbursed	Service Date	Description of product or service:	Person receiving product/service:
\$			
\$			
\$			
\$			

\$ \_\_\_\_\_ TOTAL Health Care Reimbursement Expenses Requested

**Dependent Care Reimbursement Expenses**

\$			
\$			
\$			
\$			

\$ \_\_\_\_\_ TOTAL Dependent Care Reimbursement Expenses Requested

Please attach receipts OR have your provider complete the **Dependent Care Provider Certification** below.

**Dependent Care Provider Certification:** Provider must certify that they have provided and been paid for the above services.

Provider Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

**Read Carefully:** The undersigned participant in the plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Spending Account with respect to such expenses and that the expenses have not and will not be reimbursed under any other plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes, including federal, state, or city income tax on amounts paid from the Plan with relation to such expense.

**EMPLOYEE'S SIGNATURE:**  
(REQUIRED)

**DATE:**



Did you know that you can...

- File your claim online and upload the receipt
- Sign-up for direct deposit online
- Update your account information online
- Visit [www.benstrat.com](http://www.benstrat.com)



## Health Care Reimbursement Expenses Filing Instructions

### Who is eligible?

- An employee who is enrolled in the plan, and their legal spouse or tax dependent .

### Examples of qualifying expenses

Medical, dental, vision, prescriptions and hearing expenses not covered by your health insurance.

### Documentation must show

- The date the expense was incurred (not the date paid).
- The name of provider of services.
- A description of the service and/or expense.
- The amount of the expense for which you are responsible.

Be sure to attach a copy of the itemized receipt(s), or if you have insurance, please send the Explanation of Benefits Statement. Keep original receipts for your tax records.

**Please Note:** Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.

## Dependent Care Reimbursement Expenses Filing Instructions

### Who is eligible?

- A “qualifying child or dependent” is someone whose principal place of abode is with you; who is under age 13, or physically/mentally incapable of caring for him/herself and doesn’t have income in excess of IRS tax code.

*Contact your tax or legal counsel if you have questions regarding the definition of “dependent”.*

### Examples of qualifying expenses

The receipts submitted must be for preschool or daycare expenses, before and after school programs, day camp, or care of disabled dependents.

### Documentation must show

- The date the services were provided (not the date paid).
- The name of the provider of services.
- A description of the service.
- The amount of the expense for which you are responsible.
- A provider signature may be obtained using the Providers Signature box on the claim form in lieu of a receipt.

**Please note:** Cancelled checks, credit card slips, bank statements or statements showing only a balance forward are **not** accepted as valid receipts.

### Additional Information

**Please note:** You will be required to provide the name, address and taxpayer ID number (TIN) or, if no TIN, the Social Security number of the dependent care provider on your federal income tax return. If you plan to claim a federal Dependent Care Credit on your tax returns, you must first deduct the amount you were reimbursed through your Dependent Care FSA account this year.

- The person providing the dependent care services must **not** be a parent of the child, a child of yours under the age of 19, or a dependent for whom you will be entitled to a personal exemption on your federal income tax return.
- The Dependent Care Account is **not** prefunded. Therefore, you must have sufficient funds in your Dependent Care account to cover the payment amount you are requesting.
- Expenses must be incurred on or after your effective date for the plan year and before the end of the plan year (or grace period, if adopted by the employer). **In accordance with Internal Revenue Service (IRS) rules, reimbursements will not be made until the services have been provided.**

*If you have any additional questions regarding your plan please contact us by phone at (855) HVD-FLEX (855-483-3539). Visit us online at [www.benstrat.com](http://www.benstrat.com)*