I request reimbursement for my dependent care and/or medical care expenses as itemized above. Enclosed are receipts which state: Date of service, provider name, type of service, and fee charged for the service. My signature below acknowledges my understanding of the following: 1) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source. 2) The expenses must qualify for reimbursement under the Internal Revenue Code. 3) Reimbursed expenses cannot be claimed as credits or deductions on my personal income tax. 4) Participation in a Medical FSA may disqualify me and/or my spouse from participation in a Health Savings Account (HSA). 5) I have retained copies of the documentation submitted with this request as these materials will not be returned to me. 6) The expenses listed above were incurred by myself and/or my eligible dependents as defined by the IRS.

I certify that I have provided the services as listed above.

Provider’s Signature

Date

**I request reimbursement for my dependent care and/or medical care expenses as itemized above. Enclosed are receipts which state:**

Date of service, provider name, type of service, and fee charged for the service. My signature below acknowledges my understanding of the following:

1) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
2) The expenses must qualify for reimbursement under the Internal Revenue Code.
3) Reimbursed expenses cannot be claimed as credits or deductions on my personal income tax.
4) Participation in a Medical FSA may disqualify me and/or my spouse from participation in a Health Savings Account (HSA).
5) I have retained copies of the documentation submitted with this request as these materials will not be returned to me.
6) The expenses listed above were incurred by myself and/or my eligible dependents as defined by the IRS.

**Signature Required**

Date

**Reimbursement requests must be received before 12 Noon (ET) on Tuesdays for processing that week. Requests received after this time will be processed the following week. You may e-mail your completed claim form and required documentation (receipts) to:** claims@gdynamic.com

**E-MAIL TO:** claims@gdynamic.com

**MAIL TO:** Group Dynamic, Inc. Reimbursement Benefits, 411 U.S. Route One, Falmouth, ME 04105

**FAX TO:** Reimbursement Benefits at 207-781-3841

**PHONES:** 207-781-8800 • MAINE 800-564-FLEX • US 800-626-FLEX

**WEBSITE:** www.gdynamic.com

CLM001 06/2011
DEPENDENT CARE EXPENSES

1. **Complete all pertinent information on the Reimbursement Request Form.** If you have any questions or need assistance in filing this form, please call 1-800-564-3539 within Maine or 1-800-626-3539 from elsewhere in the U.S. We will be happy to assist you.

2. Attach a copy of the invoice showing the provider’s name and address, dates of service, and the expense incurred. If your daycare provider does not issue statements, you may complete the information on the front of the Request Form. Simply have your provider sign the form in the appropriate space as verification of the information that you have provided.

3. Third party verification is required; therefore, canceled checks, check copies or credit card statements may not be used as documentation.

4. Retain originals of the invoice(s) and Request Form submitted for your personal tax records, as those you submit cannot be returned to you.

5. Incomplete Reimbursement Request Forms or those lacking proper documentation will not be processed. You will receive a letter of explanation.

MEDICAL CARE EXPENSES

1. **Complete all pertinent information on the Reimbursement Request Form.** If you have any questions or need assistance in filing this form, please call 1-800-564-3539 within Maine or 1-800-626-3539 from elsewhere in the U.S. We will be happy to assist you.

2. Attach copies of the invoices for services received. The documentation submitted must include the provider’s name, address & credentials, dates of service, description of service and the expense incurred.

3. If a service has been partially covered by insurance, send a copy of the Explanation of Benefits (EOB) received from the insurance company. Request only the amount you will actually be paying. You cannot be reimbursed for items that will be paid by your insurance.

4. Third party verification is required; therefore, canceled checks, check copies or credit card statements may not be used as documentation.

5. Retain originals of the invoice(s) and Request Form submitted for your personal tax records, as those you submit cannot be returned to you.

6. Incomplete Reimbursement Request Forms or those lacking proper documentation will not be processed. You will receive a letter of explanation.

7. In certain instances, a statement from your health care provider may be necessary to verify the medical necessity of a procedure or prescription.