ASURESOFTWARE

REIMBURSEMENT REQUEST FORM

INSTRUCTIONS TO COMPLETE REIMBURSEMENT REQUEST FORM

- Please enter the requested information for your claim to be considered for reimbursement.
- Each expense item should be entered, itemized per receipt or documentation, in the same order you are enclosing the documents.
- **PLEASE NUMBER THE TOP OF THE FOLLOWING PAGE(S) WITH THE CLAIM ITEM#.**
- Provide legible supporting documentation from an independent 3rd party for your claim (i.e. receipt, doctor's invoice/bill, or Explanation of Benefits (EOB)), which *must* include:
    - Date of service or sale date of eligible product (must match expense details entry below)
    - Name of person or organization that provided the service or product
    - Type of service provided or description of eligible product
    - Amount of expense (the portion you are responsible for paying)
- Sign and date the Request Form. Forms without a signature will not be accepted, or processed.

HELPFUL HINTS

- **Do –** Keep documentation in order (e.g. number the top of the page with the expense line item#), circle applicable items on the documentation enclosed, tape small receipt to a full sheet of paper, use as many sheets for additional expenses, and indicate whether you or your dependent incurred the expense under ***"Claimant."***
- **Do Not –** Include credit card receipts/statements, payment receipts, or canceled checks, highlight any part of the documentation, staple multiple receipts to the form or sheet of paper, mail the same form after you faxed or emailed it to Asure Software.
- **Reference the following PLAN TYPE – F** = Health FSA, **D** = Dependent Care FSA, **H** = HRA, **P** = Parking, **T** = Transit
- If you are submitting an HRA expense, make sure you are aware of the HRA Plan Design and any requirements of the type of documentation we need in order to process your claim (i.e. if you're only reimbursed for deductible expenses, the documentation provided must indicate the expense was applied towards deductible and may need to specify your *year-to-date deductible met*)

****DO NOT RETURN THIS INSTRUCTION PAGE WITH YOUR REIMBURSEMENT FORM****

RETURN THIS COMPLETED FORM TO:

ASURESOFTWARE
5100 W Kennedy Blvd. Suite 300
Tampa FL 33609
Email: processingteam@asuresoftware.com
Fax: 224-433-5229

For questions and inquiries, you may contact our Participant Support Specialists at 888-862-6272 during our normal business hours.

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REIMBURSEMENT REQUEST FORM

EMPLOYEE INFORMATION (PLEASE PRINT CLEARLY)

PAGE _____ OF _____

Employee Name: _____ Company Name: _____

Home Address: _____

☐ Check here if this is a new address

SSN: XXX - _____ - _____ Phone: _____ Email: _____

EXPENSE DETAILS

Item #	Plan Type	Plan Year	Claimant	Date of Service	Service Provider/Merchant	Expense Amount	Receipt Attached?
1							
2							
3							
4							
5							
6							
7							
8							

Dependent Care FSA Affidavit – if you have no supporting documentation regarding the daycare service(s) indicate above, you may have your daycare provider complete the following affidavit to confirm the expense incurred. Any additional burden of proof will remain your responsibility.

_____ _____

Daycare Provider Signature Date

Mass Transit/Parking Affidavit – I (employee) hereby certify that I have incurred the eligible expense(s) indicate above in the use of Mass Transit/Parking. If I am required to provide substantiation, then any additional burden of proof will remain my responsibility.

_____ _____

Affidavit Signature (employee) Date

I certify that 1) I have read the Summary Plan Description of the plan; 2) I have incurred these out-of-pocket expenses and have not previously requested payment for them from any other plan/source (i.e. tax deduction); 3) The expenses covered under this Plan are submitted as unpaid or unreimbursed by any other plan available to me; 4) The above is a true and accurate statement of unreimbursed expenses provided to me or my eligible dependents (as determined by IRS rules) on the date(s) indicated; 5) I understand I am responsible for misrepresentation regarding requests for reimbursement.

_____ _____

Employee Signature (REQUIRED) Date