



INDIANA UNIVERSITY

# TSB-HRA CLAIM FORM

## Reimbursement of Payment Request

### Employee Information

Name (Last, First, M.I.) \_\_\_\_\_

Employee ID Number: \_\_\_\_\_

Address (Street) \_\_\_\_\_

Address (City, State, Zip) \_\_\_\_\_

### Dependent Information

(For whom expenses are currently being submitted)

Dependent Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the information on this claim form is correct and authorize release of payment through my reimbursement account. I understand that reimbursement is not a guarantee that this payment is tax exempt and I am responsible for any tax consequences resulting from claiming ineligible expenses. I have not received reimbursement for these expenses previously from this or any other plan. The total of any reimbursed dependent care expenses for the plan year does not exceed either my spouse's or my earned income (W-2 pay) for the year. I understand that reimbursed dependent care expenses cannot be used to claim a credit on my personal income tax return. *I also understand that submitting false claim information could lead to termination of employment, potential prosecution and possible implications with the Internal Revenue Service (IRS). I understand that the above providers may be contacted to confirm/clarify information related to this claim.*

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Submit Claim and Documentation to:

Nyhart  
 Attn: Flex Claim Reimbursement  
 8415 Allison Pointe Boulevard, Suite 300  
 Indianapolis, IN 46250  
 FAX: (888) 887-9961  
 Customer Service: (800) 284-8412

## EXPENSES TO BE REIMBURSED

Include receipts, health claim summaries, bills, or checks (photocopies acceptable) supporting your claim. They must include the following:

- Name of provider
- Date of service
- Type of service provided
- Charge of each service

### Health Care

(Expenses must be ineligible or non-reimbursed by medical/dental plan, incurred while participating in the plan, and submitted during the claim eligibility period.)

Type of Expense	Date Incurred	Amount
<b>MEDICAL</b>		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
		<b>Total</b> \$ _____

<b>DENTAL</b>		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
		<b>Total</b> \$ _____

<b>VISION</b>		
_____	_____	\$ _____
_____	_____	\$ _____
		<b>Total</b> \$ _____

<b>OTHER</b>		
_____	_____	\$ _____
_____	_____	\$ _____
		<b>Total</b> \$ _____

### Dependent Care (For use with TSB funds only)

(Expenses must be eligible under this plan, incurred during the plan year, and submitted during the claim eligibility period.)

Type of Expense	Date Incurred	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
		<b>Total</b> \$ _____

### Dependent Care Provider

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tax ID \_\_\_\_\_