Since 1953

Benefit Administration Corporation
955 N Street
Fresno, CA 93721
(800) 282-5246 fax (559) 225-6837

Request for Reimbursement Form

Please complete applicable spaces on this form, attach appropriate bills and forward to **BAC**.

Employer________________________________ Telephone ( )__________

Employee Name________________________________
Last First Middle

☐ **Change of address** *(please check this box if new or changed)*

Mailing Address________________________________
Number and Street City State Zip

EXPENSE ITEMS

Date(s) of Service	Type*	Description ** *(see below)*	Dollar Amount
1.			$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
9.			$
10.			$
11.			$
12.			$
(Attach additional sheets if necessary)		**CLAIM TOTAL**	$

*** H - Health care reimbursement   D - Dependent care reimbursement**
***** For example, doctor co-pay, pharmacy co-pay, doctor visit, over the counter medication, etc.**

Reminder: Cancelled checks or balance forward statements are not acceptable bills. Date of service must appear on all claim support data. When applicable, attach a copy of your Explanation or Summary of Benefits (EOB) from your Insurance Company.

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not claim the expenses as an income tax deduction. I will not seek reimbursement for the expense(s) under any other plan covering health benefits.

Date ____/____ /____

Employee's Signature ________________________

For Dependent Care Provider if no receipt is attached

I certify that dependent care services were provided for the amount indicated above for the following date(s) of service: __________

____

Provider's Signature ________________________

Provider's ID Number________________________