



**GENERAL INSTRUCTIONS**

1. Complete ALL questions in parts A, B, C and/or D, and E. Refer to the reverse side for a list of eligible expenses.
2. Attach itemized bills and/or receipts to this statement. All bills must contain: (a) the identification of the service provider, (b) name of person service was provided for, (c) dates of service, and (d) itemized services rendered and amount charged for each.
3. Make sure the claim does not include items for more than one plan year. Use a separate claim form for each plan year.
4. If Group & Pension Administrators, Inc. also administers your other medical benefits, you may include a claim form for that as well.
5. If Group & Pension Administrators, Inc. does not administer your medical benefits and this is a claim for medical reimbursement, then also include a copy of your explanation of benefits from your medical plan showing the medical expenses not reimbursed.
6. After receiving a claim, the Claims Administrator will send the employee an itemized statement explaining covered and non-covered expenses.

**PART A - EMPLOYER INFORMATION**

1. EMPLOYER NAME <b>CENTENARY COLLEGE OF LOUISIANA</b>	2. PLAN # <b>H870549</b>	3. GROUP # <b>H870549</b>
---	-----------------------------	------------------------------

**PART B - EMPLOYEE INFORMATION**

1. EMPLOYEE NAME (First, Middle, Last)	2. BIRTHDATE	3. CERTIFICATE NUMBER
4. HOME ADDRESS (Street, City, State, Zip)		5. SOCIAL SECURITY NUMBER

**PART C - UNREIMBURSED MEDICAL EXPENSE CLAIMS**

1. CLAIM IS FOR: <input type="checkbox"/> Self <input type="checkbox"/> Other dependent relationship: <input type="checkbox"/> Spouse	2. PATIENT'S NAME	3. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	4. BIRTHDATE (mm/dd/yyyy)
---	-------------------	--	---------------------------

5. WAS THE ILLNESS OR INJURY CAUSED BY OR THE RESULT OF EMPLOYMENT, OR IN ANY WAY WORK RELATED?     Yes     No

6. WILL YOU OR THE PATIENT RECEIVE, OR BE SEEKING ANY MONETARY RECOVERY FROM ANY PERSON OR RESPONSIBLE PARTY?     Yes     No

6(a). IF 6 IS "YES", GIVE NAME & ADDRESS OF RESPONSIBLE PARTY:

7. IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No	7(a) NAME OF SPOUSE	7(b) BIRTHDATE (mm/dd/yyyy)	7(c) SOCIAL SECURITY NUMBER
IF "YES" COMPLETE: 7(d) NAME, ADDRESS AND PHONE NUMBER OF SPOUSE'S EMPLOYER			

8. ARE YOU OR YOUR DEPENDENTS COVERED BY ANY OTHER GROUP INSURANCE, PREPAID HEALTH PLAN, MEDICARE, OR OTHER GOVERNMENT PLAN?     Yes     No

IF "YES" COMPLETE:

8(a) INSURED'S NAME	8(b) OTHER PLAN NAME		
8(c) POLICY NO.	8(d) CERTIFICATE NO.	8(e) OTHER PLAN ADDRESS (Street, City, State, Zip)	

**PART D - CLAIMS REIMBURSEMENT DETAIL**

1. Claimant Name (Patient) <small>(Please circle M for Medical or D for Dependent Care)</small>	2. Date of Service		3. Provider Name	4. Provider Tax # <small>(Not applicable for Medical)</small>	5. Amount
	FROM	TO			
a.	M / D				
b.	M / D				
c.	M / D				
d.	M / D				

**DEPENDENT CARE NOTICE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed by the IRS to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal tax purposes, or is your child or stepchild and is under age 19.

**PART E - EMPLOYEE CERTIFICATION**

**READ CAREFULLY**

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under their employer's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 which relate to such expense.

1. DATE	2. EMPLOYEE'S SIGNATURE
---------	-------------------------

## Eligible Cafeteria Plan Reimbursement Account Expenses

Only expenses incurred during the plan year can be claimed for reimbursement. Each year is treated separately and the year of claim is the plan year the expense was actually incurred by the Participant. It is a Plan requirement that separate claim forms be used for each year.

Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. Please review your Summary Plan Description.

Allowable expenses are the same as those allowed for federal income tax purposes. A summary list is provided here for your convenience. Be advised, the IRS may revise this list from year to year. Consult IRS Publication 502 for current qualifying medical expenses.

## Qualifying Unreimbursed Medical Expenses

Only expenses NOT otherwise reimbursed may be claimed.

Ambulance hire	Eyeglasses/contact lenses	Health services	Pediatrician
Artificial limbs and teeth	Fees:	Hospital	Physician
Automobile Modifications (hand controls, special equipment, mechanical lifts)	Acupuncture	Laboratory	Physiotherapist
Braille books and Magazines	Anesthetist	Lip reading lessons for the deaf	Podiatrist
Crutches	Blood donor	Medical information plan	Practical nurse
Drugs (legal) (prescription only or insulin and medical supplies)	Chiropodist	Midwife	Psychiatrist
Elastic hose, Medically prescribed	Chiropractor	Nurse	Psychoanalyst
	Christian Science practitioner	Obstetrician	Psychologist
	Clinic	Oculist	Psychopathist
	Dentist	Ophthalmologist	Sex Therapist
	Diagnosis	Optician	Surgeon
	Diathermy	Optometrist	Therapy
	Examination, physical	Oral surgery	X-rays
	Eye exams	Osteopath	Wheelchairs
	Gynecologist		Over-the-Counter Purchases (See separate list for approved items)

## Qualifying Dependent Care Expenses

Expenses paid to a dependent care center or care provider for:

1. The care of Dependent under age thirteen (13); or
2. The care of other Dependents who are physically or mentally incapable of caring for themselves.

No payment may be made under this Plan if the service provider is your Dependent for federal income tax purposes, or is your child or step-child and is under age nineteen (19).