# BIRD ISLAND/OLIVIA/LAKE LILLIAN SCHOOL DISTRICT #2534

## CLAIM FOR REIMBURSEMENT

| EMPLOYEE NAME: | | SOCIAL SECURITY #: |
|---|---|---|
| ADDRESS: | | TELEPHONE #: |
| CITY: | STATE: | ZIP: |

### DEPENDENT CARE/ADOPTION ASSISTANCE EXPENSE CLAIMS

| Name of Dependent(s) | Period Covered | | Name, Address, SSN of Provider (Dep. Care) | Amount Incurred |
|---|---|---|---|---|
| | From | To | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Total Dependent Care/ Adoption Assistance Claim: | |

**Signature of Dependent Care Provider:**

### MEDICAL EXPENSE CLAIMS

**Effective January 1st, 2011, drugs and medicines cannot be reimbursed without a doctor's prescription.**

| Person for Whom Expense was Incurred | Date Service Provided | Name of Service Provider | Condition Treated or Name of Prescription | Net Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Total Medical Expense Claim: | |

As the participant in the above noted plans, I hereby authorize July Business Services to discuss anything relative to the payment of any of these claims with _____, as my authorized representative.

**READ CAREFULLY**

The undersigned participant in the plan certifies (i) that all expenses for which reimbursement or payment is claimed (by submission of this form) are for services rendered and were incurred during a period while the undersigned was covered under the Cafeteria Plan with respect to such expenses; and (ii) that he/she has not been reimbursed and will not seek reimbursement from another source. 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. In addition, the prescription drugs he/she is requesting reimbursement for are not for cosmetic purposes but are medically necessary.

Participant Signature:_____ Date:_____

JULY business services

**Submit by sending to:**
**July Business Services – MN Division**
**Fringe Department**
**940 Industrial Drive South, Suite 111**
**Sauk Rapids MN 56379**
**Phone: 800-682-3826**
**Fax: 866-374-7698**
**Scan and email forms to:**
**Cafeteria@julyservices.com**

## INSTRUCTIONS FOR COMPLETING THE CLAIM REIMBURSEMENT FORM

1. Please complete your claim form as follows:

2. Medical Expenses, Day Care Expenses or Adoption Expenses

   - Date the service was provided
   - Name of the service provider
   - A brief description of the procedure or expense
   - Name of the person for whom the service was provided
   - Amount claimed for reimbursement
   - If you wish to allow July Business Services to share information pertaining to this claim with individuals other than yourself (in case we need to explain what information is needed to help you get reimbursement for these expenses), you must designate an Authorized Representative on the form.
   - Attach a copy of the insurance company's EOB and/or third party receipts for the expenditures for reimbursement of any expenses.
   - Day Care Provider's signature is required

3. Read the statement regarding submitting your claim, located above the signature line. Sign and date the form.

4. When submitting a claim, include the **ORIGINAL** bill or receipt (when available) **and** EOB (Explanation of Benefits, from your insurance carrier) with your reimbursement claim form. Make a copy of the bill, receipt and EOB for your records. Submit the claim (using one of the following methods) to:

| **Mail:** | **E-mail:** | **Fax:** |
|---|---|---|
| July Business Services - MN Division<br>Fringe Department<br>940 Industrial Drive South, Suite 111<br>Sauk Rapids, MN 56379 | cafeteria@julyservices.com | (866) 374-7698 |

5. **The Employee is the only person eligible to sign the Reimbursement Claim Form!**

   **We cannot pay a claim without all of the above information.**

   **If there is any other reason why we cannot make reimbursement to you, we will notify you in writing and you may resubmit the claim for reimbursement with the proper documentation.**