

**MICHIGAN STATE UNIVERSITY  
PLAN NO.: 0234  
FLEX BENEFIT PLAN  
REIMBURSEMENT REQUEST**

**MAIL COMPLETED FORM TO:  
Meritain Health  
P.O. Box 30111  
Lansing, MI 48909  
(800) 748-0003  
Fax (517) 381-6600**

**CLAIMANT DATA**  
(PLEASE PRINT OR TYPE)

EMPLOYER NAME: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CHECK HERE IF THIS IS A NEW ADDRESS

**HEALTH CARE REIMBURSEMENT EXPENSES**

Claimant's Name, Birth Date & Relationship to Employee	Date Incurred	Amount Eligible For Reimbursement
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

**ATTACH ITEMIZED BILL(S) OR INSURANCE EXPLANATION OF BENEFITS.**

I have HEALTH insurance: Yes  No  DENTAL insurance: Yes  No  VISION insurance: Yes  No

**DEPENDENT CARE REIMBURSEMENT EXPENSES**

Dependent's Name, Birth Date & Relationship to Employee	Date Incurred	Amount Eligible For Reimbursement
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

**PLEASE PROVIDE DEPENDENT CARE PROVIDER'S NAME, ADDRESS AND SOCIAL SECURITY OR TAX I.D. NUMBER BELOW:**

NAME: \_\_\_\_\_ S.S.# OR TAX ID#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**DEPENDENT CARE PROVIDER SIGNATURE:** \_\_\_\_\_

\*I certify that Dependent Care expenses submitted have been incurred for the care of a "qualifying individual" to enable me to be gainfully employed. I understand that a qualifying individual is (i) a dependent of mine under age 13, (ii) a dependent of mine or my spouse who is incapable of caring for himself/herself. I also certify that my spouse, if any, was either employed, a full-time student, or incapable of caring for himself/herself during the period when expenses were incurred.

**TOTAL AMOUNT ELIGIBLE FOR REIMBURSEMENT = \$ \_\_\_\_\_**  
 2008 Plan Year  2009 Plan Year

I hereby certify that the information contained in this Claim for Reimbursement Benefits is to the best of my knowledge and belief true and correct, and each item of expense is eligible for reimbursement. I understand that I am responsible for providing proof to support a reimbursed expense and any reimbursed expense later discovered to be not eligible for reimbursement will be taxable to me.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

You **must** sign this form to be reimbursed.

**NOTE: INCOMPLETE CLAIM SUBMISSION MAY RESULT IN PROCESSING DELAYS. BE SURE TO INCLUDE ALL NECESSARY INFORMATION, SIGN AND DATE FORM.**