



# PREMIUM REIMBURSEMENT ACCOUNT REIMBURSEMENT REQUEST FORM

FAX TO: 303-221-2785

PAGE 1 OF \_\_\_\_\_

IT IS NOT NECESSARY TO INCLUDE A COVER SHEET

## PLAN & EMPLOYEE INFORMATION

Check here if you have an address or name change

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

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

DAYTIME PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ PLAN YEAR: \_\_\_\_\_

## INSURANCE EXPENSES

\*\*\*\*\*PLEASE DO NOT HIGHLIGHT DOCUMENTATION/RECEIPTS OR ITEMS ON THIS FORM IF YOU WILL BE FAXING\*\*\*\*\*

COVERAGE PERIOD	INSURANCE PROVIDER/CARRIER	PREMIUM AMOUNT
<b>TOTAL EXPENSES</b>		

## REIMBURSEMENT INFORMATION<sup>2</sup>

Please pay this claim by Direct Deposit to my specified account already on file with PBS.

Please issue a check for this claim.

Please pay this claim by Direct Deposit using the new information provided below.

\*If you do not select a box above, your reimbursement will be processed in the manner we have on file.

I hereby authorize Planned Benefit Systems, Inc. to initiate credit entries for my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Planned Benefit Systems, Inc. has received written notification from me of its termination in such time and in such manner as to afford Planned Benefit Systems, Inc. a reasonable opportunity to act on it.

ACCOUNT NUMBER: \_\_\_\_\_ ROUTING NUMBER: \_\_\_\_\_  
Must be 9 digits

BANK NAME: \_\_\_\_\_  CHECKING ACCOUNT  SAVINGS ACCOUNT

## EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these expenses will not be claimed again when filing IRS form 1040 and that they were incurred for me or my eligible dependents. I certify that these expenses have not already been reimbursed under this plan or any other plan and are not reimbursable under any other coverage or employer plans. I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand.

**PLANNED BENEFIT SYSTEMS CANNOT PROCESS THIS REIMBURSEMENT WITHOUT A SIGNATURE BELOW**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Planned Benefit Systems, Inc. • [www.cci-pbs.com](http://www.cci-pbs.com)  
P.O. Box 4594, Greenwood Village, CO 80155-4594  
Customer Service 800-800-0133  
Fax 303-221-2785

## HOW TO FILE YOUR REIMBURSEMENT REQUEST

COMPLETE AND SIGN YOUR THIS FORM AND REMIT ALONG WITH DOCUMENTATION/RECEIPTS TO PBS IN ONE OF THE FOLLOWING WAYS:

FAX: 303-221-2785

MAIL: PLANNED BENEFIT SYSTEMS, INC.  
P.O. BOX 4594  
GREENWOOD VILLAGE, CO 80155-4594

EMAIL: [pbsclaims@cci-pbs.com](mailto:pbsclaims@cci-pbs.com)

PLEASE KEEP A COPY OF THIS FORM AND YOUR ORIGINAL DOCUMENTATION/RECEIPTS FOR YOUR RECORDS.

### TIPS FOR FILING YOUR REIMBURSEMENT REQUEST

Submit Insurance Provider/Carrier receipt(s) that includes the following information:

- ✓ Name of Insurance Provider/Carrier
- ✓ Address of Insurance Provider/Carrier
- ✓ Date of Coverage
- ✓ Premium Amount
- ✓ Plan Description

Cancelled checks, credit card receipts or statements that only show a "Balance Due" are not acceptable forms of substantiation.

### THINGS TO REMEMBER ABOUT REIMBURSEMENTS

- The only expenses eligible for reimbursement under this plan are non-employer sponsored health insurance premiums for you and your eligible dependents.
- Services must be rendered during the plan year while you are an active participant.
- If you have entered the plan mid-year or terminated participation, only expenses incurred while you were an active participant are eligible for reimbursement.
- Your claim will be processed within 7 to 10 business days. You will receive notification by mail, thereafter, if any portion cannot be paid for any reason.

<sup>1</sup> **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, [help@cci-pbs.com](mailto:help@cci-pbs.com), to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at [www.cci-pbs.com](http://www.cci-pbs.com). Select *Planned Benefit Systems*, then *Account Information* under the Participants section and then log in under Employee and Cardholder Login. PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.

<sup>2</sup> **Reimbursement Information:** The initial direct deposit may take up to 10 days to process. Subsequent direct deposits normally take 2 business days from date of initiation. Bank holidays/weekends may affect when the deposit is credited to your account. Please contact your bank to verify all deposits are received. There will be a \$25 fee to reissue lost/stolen checks.

Planned Benefit Systems, Inc. • [www.cci-pbs.com](http://www.cci-pbs.com)  
P.O. Box 4594, Greenwood Village, CO 80155-4594  
Customer Service 800-800-0133  
Fax 303-221-2785