REIMBURSEMENT REQUEST FORM

Employer Name____________________________________ Guardian Group Policy Number G-________________

Employee Name ____ Location ________________________

Employee Mailing Address ____

Employee's E-mail Address ____

SSN or Member ID ________________________________ Daytime Phone No. ______________________________

"Preference will not be given to claims by date of service, claims will be processed in the order they are received." Please list below the amount(s) of reimbursement you are requesting. Copies of this form, along with the receipts for expenses that are eligible for reimbursement, must be forwarded to the Guardian FlexPlan.

HEALTH CARE REIMBURSEMENT ACCOUNT (FSA)

Amount of reimbursement requested: $_____________ Applies to Plan Year _____________

Date Incurred	Dependent Name	Dependent Date of Birth	Out of Pocket Expense

Do you have Dental Insurance? No Coverage ☐ (Guardian Dental PPO ☐ DHMO ☐) (Other Dental PPO ☐ DHMO ☐)
Do you have Medical Insurance? No Coverage ☐ (Guardian Medical ☐) (Other Medical ☐)

Federal law requires that you submit a written statement (such as an itemized bill from the service provider) as well as proof that the claim is not being reimbursed by an Insurance Company. **Please submit copy of EOB (Explanation of Benefits) if the expense is an insured benefit.**

Certification and Authorization

I certify that the above information is correct and hereby authorize release of payment through my reimbursement account(s). I further certify that these expenses have not been and will not be reimbursed by any other health coverage, or any other plan. I understand that I am fully responsible for the accuracy and sufficiency of all information relating to this claim.

I agree to notify my Employer if I have reason to believe that any expense(s) for which I have obtained reimbursement is not an eligible expense, and also agree on demand to indemnify and reimburse my Employer for any liability it may incur for failure to withhold Federal and State income tax or Social Security tax for any reimbursement I receive for an expense which does **not** qualify as an eligible expense, up to the amount of additional tax actually owed by me.

Employee Signature ____ Date ______________________________

Return this form to: Guardian FlexPlan, P.O.Box 26290, Lehigh Valley, PA 18002-6290
Phone: 1-866-359-4542 Fax: 610-807-8830 www.guardianflexplan.com FlexPlan@GLIC.com

All claims should be submitted with a signed and dated reimbursement request form

Claim Reimbursement Instructions

Things to Remember When Submitting Claims

To help prevent delays in the processing of your reimbursement request, when submitting claims the following information should be included:

Type of claims	Information needed with claim form
Over the counter products used for the treatment of a medical condition. (Tylenol, Advil, Allergy medication, etc.) See web-site for list of eligible over the counter products	Store receipt with prescription, date of service, name of item and charged amount. (If dual purpose product: letter of necessity by physician) **
Over the counter products (such as bandaids, contact solution, insulin, etc) See web-site for list of eligible over the counter products.	Store receipt with date of service, name of item, and charged amount. (If dual purpose product: letter of necessity by physician) **
Prescriptions/RX Copays	Actual RX receipt or print out from the pharmacy with patient's name, date of service and type of medication. **
Office Visit Copays	Statements with name of patient and date services were rendered. **
Co-insurance/Deductible	Explanation of Benefits (EOB) from your Major Medical or Dental insurance carrier. **
Orthodontia	Contract from the Dentist and Explanation of Benefits (EOB) from dental carrier.

The receipt or documentation must contain:

- **Provider Name –** Who provided the service or where item was purchased.
- **Date of Service** – Date services occurred or date item was purchased.
- **Service Description** – Detailed description of what service or product was paid for.
- **Amount** – The amount paid for the services or product and/or the portion not reimbursed through your insurance carrier.
- **Patient Name** – Person who received the service or who the item is for. For over the counter purchases this is not necessary.

- Credit card receipts, cash register receipts and cancelled checks are not acceptable for reimbursement because they do not reflect patient's name, provider's name and date of service.
- For information on how orthodontia claims are processed, please call our toll free for a detailed explanation.
- All claims should be submitted with a signed and dated reimbursement request form.
- If your claim requires a physicians letter of medical necessity a separate form is required which can be located in our document library on our website, www.guardiananytime.com.
- ** If you have a limited healthcare Reimbursement Account, only dental, preventative and vision services are eligible for submission. Please refer to your company's Summary Plan Description for further detailed information.

After Submitting Claims

- **Please wait 5 business days after submitting your claim before contacting us for status.**
- You can also verify if your claim was processed by visiting www.guardiananytime.com.

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