Please fax, email, or mail to:
**Goldleaf Partners**
Benefits Management
PO Box 806
Brainerd, MN 56401

**Email**: benefits@goldleafpartners.com
**Phone**: (866) 882-8442
**Fax**: (480) 782-1842

# CLAIM FORM

## 1. Participant Information (Please Print or Type)

Employee Name (First, MI, Last) | Date of Claim

Social Security Number (**last 4 digits**) | Employer

Email address | Daytime Phone Number | Home Phone Number

☐ Check here for New Address

Address (Street, City, State, and Zip)

## 2. Spouse / Dependent Information (If expenses were for your Spouse/Dependent)

Your dependent is your spouse, child or other person for whom you may take a deduction under the Internal Revenue Code.

| Spouse/Dependent's Name | Date of Birth (01/01/01) | Social Security Number (last 4 digits) | Relationship |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**Dependent/Child Care Claims** (Tuition/Prepays are NOT Eligible)

| Dependent # (per list above) | Period Covered From | To | Name & Address of Service Provider | Amount Incurred |
|---|---|---|---|---|
| | | | | |
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**Please send copies of receipts with Claim Form** | **Total Dependent/Child Care Claims** | $

**Reimbursement of dependen/childt care claims are subject to the rules applicable to deductible dependent care expenses under the Internal Revenue Code and the provisions of your Cafeteria Plan.**

**Medical Reimbursement Claims (Transactions must all be listed by provider and totaled)**

| Dependent # /Self (per list above) | Date Expense Incurred From | To | Name of Service Provider (Example: CVS Pharmacy) | Expense Description (Example: RX or OTC) | Amount Incurred |
|---|---|---|---|---|---|
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**Please send copies of receipts with Claim Form** | **Total Medical Reimbursement Claims** | $

The undersigned participant in the Plan certified that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was active under the applicable Company's Cafeteria/Flexible Benefit Plan. Participant certifies that the medical expenses submitted have not been reimbursed nor will seek reimbursement or are not reimbursable under any other plan. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim. Participant understands that he or she may be required to verify these expenses in the event of an audit by the IRS.

Participant Signature | Date

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**CLAIM FORM**

## CLAIM FILING INSTRUCTIONS

Listed below are procedures for submitting claims which will help to ensure prompt and efficient processing of a participant's claim.

1. Make sure that the claim form is complete in ink, including Social Security number, employer name and **participant's signature**. Transactions must all be listed by provider and totaled.
2. Use separate claim forms for separate plan year expenses. Only expenses incurred during the appropriate plan year and while an active participant are eligible.
3. All prescription, medical and dental expenses must first be submitted to health or dental insurer, if any. If there is no other health or dental care insurer, please submit expenses directly to Administrative Firm. Prescriptions: please send either the prescription stub that includes the drug name, or an itemized statement from your pharmacy that includes all of the required information. Over-the-counter: for these items you are permitted to submit the cash register receipt. If the receipt does not clearly state what the OTC item is, please write on the receipt copy or on a separate piece of paper an exact description of the item.
4. Per Department of Labor audit requirements, copies of receipts or **Explanation of Benefit Statements** (EOB's) from the health care insurer, if any, should be submitted. EOB's may be obtained online from your health plan.
5. Only medical expenses that qualify under dual requirements of Code 213 and Prop Treas. Reg 1.125-2 are eligible for reimbursement. Receipts must clearly state person for whom service was rendered, date of service, name of provider, detail of service rendered, and price of service.
6. All receipts for dependent care must include the name of the provider of services, provider's individual Social Security number or Federal Tax I.D. number, the names(s) of person(s) for whom the service was provided, actual date of service, and an itemized list of charges. Child must be under 13 years of age. Tuition, prepays and Kindergarten are ineligible. Dependent care is to enable you to work. Stay at home parents can not place children into daycare and be reimbursed.
7. For first time filing of orthodontic claims please include a copy of the contract and schedule of payments. Thereafter, simply submit a claim form with the receipt and indicate that it is for an orthodontic treatment expense.
8. Please allow three business days prior to run date for claims to be processed.
9. Retain copies of all items submitted to Administrative Firm for reimbursement.
10. If claims are submitted for dependents, you must complete Section 2 only Federal tax dependents expenses are eligible.

## CLAIM REVIEW PROCEDURES

It is possible that at some time during an employee's participation in a cafeteria plan, a claim for benefits will be denied. If this happens, and the participant wishes to appeal the decision, there are several safeguards in place to protect your rights as a participant.

**The Review Procedure**. The Administrative Committee will make a decision concerning a participant's claim within 30 days of notification. In exceptional cases this time may be extended, but under no circumstances can the decision be delayed longer than an additional 15 days. The participant must be notified if an extension is necessary.

**If a Claim is Rejected**. Claim rejections fall into two basic categories:

(a) If the claim DOES NOT QUALIFY as an included benefit under the cafeteria plan, the participant will be notified of the reason.

(b) If the participant files for an included benefit but the claim is rejected because it was IMPROPERLY FILED, the participant will be told what additional paperwork or changes are needed before refilling the claim.

**The Appeals Procedure**. If a participant decides to appeal a claim decision, the specific legal rights as a participant are;

(a) The participant or appointed representative may request a review of the case by submitting a written application to the Administrative Committee. This request must be submitted within 180 days of when the participant was first notified of the claim denial.

(b) The participant may review any related case documents.

(c) The participant may submit a written statement concerning the claim.

It is important that the review process be fair and nondiscriminatory. The participants have specific rights outlined more in-depth in the cafeteria plan document. The participant must receive a written notice of the final decision of the Administrative Committee. It will include the specific reasons for the Committee's decision.

**THIS PAGE IS NOT NECESSARY TO SUBMIT FOR PROCESSING THANK YOU.**