Leavitt Group

WEBBER ADVISORS

Reimbursement Claim Form

Please complete the below information to request reimbursement of expenses incurred by your and/or an eligible dependent(s).

NOTE: Federal law requires that you submit itemized documentation of each expense (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by an Insurance Company. Also, you will not be entitled to claim this expense as a tax deduction. If you have any questions, please contact our Claims Department at 1-800-326-9850 Monday through Friday 8:00 a.m. to 4:00 p.m.

Participant Information	
Participant Name:	
Employer Name:	
Last 4 of Employee SSN:	
Email Address:	

Please list each eligible expense below

Under the **Plan Type** column, select one of the following plan codes for each expense listed to which you are enrolled. *Please Note:* If your employer has FSA Debit Cards (Cloud Card) and the card was used for the expense, please mark below

FSA – Health FSA **LPFSA -** Limited Purpose Health FSA **DCA –** Dependent Care Account **HRA-**Health Reimbursement Arrangement

TRN-Transportation **DENT**-Dental/Vision

Paid with Cloud Card	Plan Type	Whom Incurred Expense	Date of service	Name of Service Provider	Describe Expense	Dollar Amount

TOTAL CLAIM AMOUNT: $

You may also file your FSA or DCA claim online via your employee portal (https://webberadvisors.lh1ondemand.com) or mobile app. *Please note*, all HRA or Direct Dental claims must be submitted via Reimbursement claim form with explanation of benefits or detailed receipt for dental claims

Submit your claim form with supporting documentation via fax to 814-317-1610.

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the employers enrolled Cafeteria Plan (FSA/DCA/Direct Dental/Transportation Accounts/HRA) with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. 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 the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Signature	Phone Number:	Date