Flexible Spending Plan Reimbursement Voucher

SELECT ☐ PG Plus™ ☐ PG Blue™

Note: Please read the back of this form for instructions on how to complete this voucher

EMPLOYER / GROUP NAME

PARTICIPANT NAME (LAST, FIRST) SS NUMBER (LAST 4 DIGITS)

PARTICIPANT ADDRESS CITY STATE ZIP

☐ Please check this box if this is a change of address or log in and change your address on the Profile tab on the Benefit Portal at www.MyTPGPlan.com

Medical / Health FSA

Receipts must include description, date, and amount of service.

Nature of Service	Date(s)	Amount
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
	TOTAL	$ 0.00

Dependent/Child Care Expense

Receipts must include date of service, amount, and SS# or Tax ID ***OR*** *have provider fill out and sign below*

Name of Day Car Provider	Signature of Provider	SSN/Tax ID

Name of Dependent(s)	Age (0 thru 12 only)	Disabled (any age)
1		☐ Disabled
2		☐ Disabled
3		☐ Disabled

Description of Service	Date(s)	Amount
1		$
2		$
3		$
4		$
TOTAL		$ 0.00

Premium Expense

Privately held insurance policies for: Vision, Dental, Supplemental, Medicare Supplement and COBRA
No privately held Life, Long Term Care, Medicare, Major Medical or Exchange policies

Type of Insurance	Dates of Coverage (From / To)	Amount
		$
		$
	TOTAL	$ 0.00

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for recrediting To my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

SIGNATURE (Must be signed to receive reimbursements) DATE

Mail completed vouchers to:
Preferred Group Plans, Inc.
PO Box 15136
Albany, NY 12212-5136

-OR-

Email completed vouchers tp"
Claims@tpgplans.com

-OR-

Other Contact Information:
Claims Fax Line: (518) 641-0325
Claims Helpline: (866) 989-8995
Email General Questions to:
benefits@tpgplans.com

* HOW TO COMPLETE YOUR REIMBURSEMENT VOUCHER *

FILLING OUT YOUR REIMBURSEMENT VOUCHER:

- Fill out *your* employer's name, *your* name and *your* address. The address on the voucher is the address to which your check will be sent. *If there is a change of address, please check the "Change of Address" box.*
- Be sure to fill in your Social Security Number and your home and work telephone numbers.
- *Sign* and date your voucher. Your claim cannot be processed without your signature.
- Please provide a specific description of your expenditures under the "description" column.
- Fill out the total amount of your claim in each category — Medical, Dependent Care and Premium Expense.

SUBMITTING YOUR CLAIMS FOR REIMBURSEMENT:

- Please be sure that the claims that you are submitting for reimbursement are allowable expenses. There are some specific expenses that are not allowed under various Flex plans. For example, cosmetic procedures, child care while one spouse is at home, and premiums for group-term life insurance are not reimbursable expenses.
- You will need to attach *copies of third-party invoice(s)* to substantiate your claim. These may include receipts, insurance Explanation of Benefits (EOB) or other documentation. *Canceled checks cannot be accepted as proof of a reimbursable expense*. Each invoice must contain the following information:
  - *Date of Service*. Reimbursement is made based on date of service, not on date of payment.
  - *Nature of Service*. Receipts must specify the nature of service so that we may determine its eligibility under the Flex Plan.
  - *Individual Receiving Service*. Only plan participants and their dependents may be eligible for Flex benefits.
  - *Amount of Service*. Please provide documentation indicating the cost of services for which you are responsible.

UNREIMBURSED MEDICAL EXPENSES:

- Certain UNREIMBURSED MEDICAL EXPENSES may require a prescription from a licensed physician indicating the medical necessity, and condition, for which the items are required. A new prescription is required for each condition, and for continuing conditions at the beginning of each plan year.
- Certain FDA approved Over-the-Counter drugs and medicines which are used to treat an illness or injury may be reimbursed with a third-party receipt showing the printed date of purchase, description, dollar amount and name of provider.
- Expenses covered by your insurance can only be submitted to PGP *after* they have been submitted to your insurance carrier. When you receive your Explanation of Benefits, submit the *unpaid balance* to PGP. We cannot reimburse you before we know how much of your claim will be covered by your insurance carrier.
- Expenses *not* covered by your insurance should be submitted along with a statement from either you or your insurance carrier indicating that the expenses will not be reimbursed.

DEPENDENT DAY CARE:

- For DEPENDENT DAY CARE claims please list your provider's name and either Social Security or Tax ID number.
- If no receipt is provided, please have your daycare provider complete the dependent day care section of this voucher and sign the appropriate box. *
- You can submit vouchers at any time, but you will only be reimbursed up to the amount that is in your Dependent Day Care Account at the time your voucher is received. The balance of the claim will be paid automatically as money is deposited in your account.

PREMIUM EXPENSE:

- Please make sure that the expenses that you are planning to claim are eligible and that you have this benefit.
- For PREMIUM EXPENSE claims, provide a third-party invoice showing the type of health-related insurance, the time period the insurance covers, the individual receiving coverage, and the amount of the premium. You will be reimbursed only for the coverage that falls within your plan year.

Flex Account Questions? Contact Benefits Info at **(800) 573-7474 (8AM-6PM, M-F)**
OR Log In to the Benefits Portal at **www.MyTPGPlan.com**
OR Email **Benefits@tpgplans.com**

Other Contact Information:
Claims Fax Line: (866) 539-1394