IBM Reimbursement Request Form
Health Care Spending Account

INSTRUCTIONS

- Fill in the information requested below for the medical expenses you or your eligible dependents have incurred.
- For each item, you must include a copy of a receipt showing the date of service or a copy of an explanation of benefits (EOB) from your insurance carrier. Each receipt must show the **provider's name, patient's name, original date of service, expenses incurred, and the type of service, treatment or prescription** (including the name of the medication). Canceled checks are not considered eligible receipts per Internal Revenue Code (IRC) Section 125 Regulations. Please retain your original receipts and claims filed for your records.
- Receipts for **over-the-counter (OTC) medications** must show the purchase date and the name of the medicine or drug. Please circle the expense and medication or drug name on your receipt. An EOB form is not required for eligible OTC medications.
- **Expenses incurred during the 2½-month grace period after the end of the plan year can be reimbursed from your prior or current plan year funds.** To request reimbursement from your:
  - **Prior plan year funds**, complete this form and check the Grace Period box (below) on the form.
  - **Current plan year funds**, complete a separate form and do not check the Grace Period box (below) on the form.

  You cannot use the same form to request reimbursement from both the prior and current plan years. If the Grace Period box is not checked, your reimbursement will be paid from your current year funds.
- The deadline for filing claims is **June 30 (postmarked by this date)** of the calendar year following the one in which expenses are incurred or being applied to.
- All information submitted with this form will be protected and maintained as required by law.

If you have any questions about your account status, virtually 24 hours a day, 7 days a week, please contact us at www.acclarisonline.com or call the Acclaris Reimbursement Center toll-free at 1-888-880-2775, Monday through Friday (excluding New York Stock Exchange holidays) between 8:00 A.M. and 8:00 P.M. Eastern Standard Time to speak with a Customer Service Representative.

Please fax your completed reimbursement request to: 1-813-830-7900

Or mail to: Acclaris Reimbursement Center, PO Box 25171, Lehigh Valley, PA 18002-5171

HEALTH CARE REIMBURSEMENT REQUEST

☐ **Grace Period (Apply all expenses included with this claim form to my prior plan year funds.) See instructions above.**

Date of Service	**Service Provider** (Name of Clinic, Doctor, Pharmacy, Store, etc.)	**Description of Expense** (For Drugs or Medications, Provide Name)	**Amount Paid** (Total Expense)	**Amount Paid By Insurance** (If Any)	**Amount Paid By You**

Additional expenses can be submitted by attaching additional pages that include the details required above.

Total Unreimbursed Health Care Claim $_______________

Mileage – Medical Travel Reimbursement	**Mileage:**	The mileage reimbursement rate is based on the current IRS standard deduction, which is available on the Frequently Asked Questions section of the Acclaris Web site (www.acclarisonline.com).
	Date of Service:	

CERTIFICATION AND DATE

I authorize release of any information relating to this claim to IBM, its contract administrators, or their representatives, as necessary to determine the validity or amount payable on account of this claim. I agree that IBM's contract administrators may release to IBM, or any contract administrator designated by IBM, upon IBM's request, any records and information in its possession in connection with this claim.

I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse and/or eligible dependents, as defined in Internal Revenue Code Section 152) and that the descriptions of these expenses are accurate and meet the guidelines specified under Internal Revenue Code Sections 105 and 125, and supporting IRS Regulations. I certify that any over-the-counter medication or drug requested above was purchased for myself (and/or my spouse and/or eligible dependents, as defined in tax code Section 152) for medical care and was not purchased for general good health.

A copy of the authorization shall be as effective as the original. I certify that all the information provided is true and correct and that none of the expenses submitted have been or can be reimbursed under any other plan or insurance. I understand that expenses reimbursed from my IBM Health Care Spending Account cannot be taken as tax deductions.
I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties, and will hold Acclaris harmless for payment of any ineligible expenses presented in such a manner.

Signature of Participant: ______________________ **Date:** ______________

(Please print the requested information below. Only the last four digits of your Social Security Number are required.)

Name: ______________________ Daytime Phone No.: ( )

Social Security Number: XXX-XX-__________ E-Mail Address: ______________