ASI ADMINISTRATION SPECIALISTS INC. • 6370 Normandy Street • Saginaw, MI 48638
• **Phone:** (989) 793-8844 | 1-800-228-3544 • **Fax:** (989) 799-3692
• **Web:** www.ASI401K.com

REQUEST FOR REIMBURSEMENT FROM EMPLOYEE HEALTH CARE SPENDING ACCOUNT

INSTRUCTIONS
Complete all information, and be sure to sign certification statement
Each expense you submit must be properly documented. For a description of acceptable documentation, please see reverse side of this form.
Attach the documentation securely to the form, retaining copies for your own records.
Send you request for disbursement to: A.S.I. 6370 Normandy St., Saginaw, MI

EMPLOYEE INFORMATION

Employer

Employee Name _____ Social Security No. _____

Home Address _____ City _____ State _____ Zip _____

☐ Check this box if your address has changed since your last request for disbursement

HEALTH CARE EXPENSES

Name of Person for Whom health care service was provided	Date of Service FROM	TO	Provider of Service	Total Charge	Amount paid by other source	Amount to be Reimbursed
			TOTALS			

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:
__They were incurred for services or supplies received by me or my eligible dependents under the plan.
__They were for services or supplies furnished on or after the date I began participating in the plan.
__I have not been reimbursed for these expenses and they are not reimbursable from any other health plan.

I understand that reimbursement of these expenses can be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered.

I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account.

I understand that reimbursement will be made in accordance with the provisions of the plan in which I participate. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

_____ _____
EMPLOYEE SIGNATURE DATE