

Health Care Reimbursement Account Request
Fermi National Accelerator Laboratory

A. INSTRUCTIONS

- COMPLETE SECTIONS B, C, AND D
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER
- ATTACH EXPLANATION OF BENEFITS (EOB) FROM THE INSURANCE CARRIER OR CO-PAY RECEIPTS
- IF YOU ARE SUBMITTING AN ITEMIZED BILL ONLY, INDICATE WHY THIS BILL HAS NOT BEEN PAID BY YOUR INSURANCE PLAN (SPACE PROVIDED ON REVERSE OF THIS FORM)
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:
 - PROVIDER NAME AND ADDRESS
 - PATIENT NAME
 - ITEMIZED CHARGES
 - DATE OF SERVICE
 - TYPE OF SERVICE
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS, AND BALANCE DUE BILLS ARE **NOT ACCEPTABLE** PROOF OF EXPENSES
- IF YOU HAVE ANY QUESTIONS, PLEASE CALL: 800.242.2269
- FOR GENERAL INFORMATION/CLAIM FORMS, VISIT OUR WEBSITE: www.cigna.com/fsa
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO: **CIGNA REIMBURSEMENT ACCOUNTS
 P.O. BOX 0976
 BRISTOL, CT 06010**

B. EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NUMBER	COMPANY NAME Fermi	ACCOUNT NUMBER(S) 3208852
LAST NAME	FIRST NAME	
ADDRESS	CITY	STATE ZIP CODE

C. HEALTH CARE EXPENSES

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE: DENTAL COVERAGE? YES* NO
 MEDICAL COVERAGE? YES* NO
 VISION COVERAGE? YES* NO

* IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.

PATIENT NAME	PROVIDER (I.E., DOCTOR NAME/ PHARMACY NAME)	DATE(S) OF SERVICE	TOTAL CHARGE A.	AMOUNT PAID BY OTHER SOURCES B.	AMOUNT TO BE REIMBURSED (A - B = C)

TOTAL REIMBURSEMENT REQUEST: \$ _____

D. CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred for services or supplies by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my employee spending account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should 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 or will not 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. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE <i>(Required)</i>	DATE
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ADDITIONAL INFORMATION

(If applicable, please use this space to explain why this bill is not being paid by your insurance plan.)