



Number of pages faxed

ICUBA Benefits Administration
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All claims are processed within 2-3 business days

Reimbursement Request Form

SECTION A- EMPLOYEE INFORMATION

Name _____

Mailing Address _____

City, State, Zip _____

Daytime Phone # _____

Email Address _____

If you have an address change, be sure to update your records with your employer.

Is this a new address (check one) Yes No

Social Security # _____

Employer _____

Complete the information below for expenses incurred by you, your spouse or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete, it will be returned to you. Please send photocopies of forms and documents. Keep originals for your records.

SECTION B-EXPENSE TO BE SUBMITTED

You can also file your claim online at our secure site at <http://icubabenefits.org>, upload your documentation directly to the site or print a confirmation sheet and fax or email it to us with your supporting documentation.

Expense Type (check only one per row)			Provider of Service	Person Receiving Service	Dates of Service (from-to) Format dates: mm/dd/yy	Nature of Expense	Amount of Expense
FSA	HRA	DCSA					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Day Care Providers Tax ID # (Signature if individual) _____

The day care provider's Tax ID # can be substituted for the supporting documentation

\$ _____

TOTAL amount to be reimbursed

SECTION C-EMPLOYEE CERTIFICATION

I request payment for my health care expense or dependent day care expense account as indicated above for the expense listed. To the best of my knowledge and belief, my statements in this reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred during the plan year and for me and my eligible dependents. I certify that these expenses have not and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HCSA/DCSA/HRA to reimburse me by the amount requested.

**SIGN AND DATE
FORM EACH TIME**

SIGN **SIGN** **SIGN**

I certify this claim in accordance with Section C-Employee Certification. Unsigned claims will automatically be denied.

Participant Signature _____ Date _____