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FLEXIBLE SPENDING ACCOUNT REQUEST FOR DISBURSEMENT HEALTH CARE EXPENSES

Company ID Number 026

Instructions (please read carefully):

- If you are submitting expenses for more than one calendar year, you must submit a separate form for each year that you participated in the Health Care Spending Account.
- Expenses submitted for reimbursement must be documented. For a description of acceptable documentation, please see the reverse side of this form.
- Complete all information and sign the certification statement in Section III.
- Attach all documentation (bills, invoices, receipts) securely to the form.
- Keep copies of all documentation for your own records.
- Send your completed Request for Disbursement form to:UMR- Arcelor Mittal, P.O. Box 8022, Wausau, WI 54402-8022 Fax # 1-877-390-4782 Email: umr-fsa@umr.com
- For questions regarding the status of your Flexible Spending Account, call 1-877-310-FLEX.

I. **Employee Information:** _____ _____

Last Name, First Name, Middle Initial *Social Security Number*

_____

Mailing Address

Have you moved since your last request for disbursement? Yes___ No___ If yes, is this your new address? Yes___ No___

II. **Medical Care Expenses:**

Provider of Service	Service Dates From - To	Total Charge	Amount Paid By Other Sources	Amount to be Reimbursed
Totals				

III. **Certification**

I certify that the expenses for which I am requesting reimbursement were incurred for services or supplies received by me or my eligible dependent(s) under my Health Care Spending Account and that 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 nor will I 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.

_____ _____ _____

Employee Signature *Payroll Number* *Date*

Acceptable forms of documentation:

- Explanation of Benefits (EOB) form.

- A receipt from a provider must be on the provider's letterhead or billing form and must include the following information:
  - Name of the patient
  - Date of service
  - Description of service
  - Amount charged for service

- A receipt for prescription drugs and eligible equipment, appliances, or supplies must indicate the following information:

  - Name of the patient
  - Description of item
  - Amount charged for service
  - Prescription number
  - Name of prescribing physician
  - Date of purchase (or rental date in the case of eligible equipment, appliances, or supplies)

Only EOBs and itemized receipts or statements will be accepted. Receipts indicating a balance forward, amount due, or similar wording are not acceptable. Canceled checks without accompanying provider receipts or statements are not acceptable.