Employer's Name

____

Claim Form
Reimbursement of Payment Request

Employee Information

____
Name (Last, First, Middle Initial)

____
Social Security Number ***(Last Four Numbers are required)***

____
Address (Street)

____
Address (City, State, Zip) ☐ Check Here If New Address

Names of Dependents:
(For whom expenses are currently being submitted)

Dependent Name	DOB	Relationship

I hereby certify that the information on this claim form is correct and authorize release of payment through my reimbursement account. I understand that reimbursement is not a guarantee, that this payment is tax exempt. I have not received and will not receive reimbursement for these expenses from this or any other plan. The total of reimbursed dependent care expenses for the plan year does not exceed my or my spouse's earned income (W-2 pay) for the year. I understand that reimbursed dependent care expenses cannot be used to claim a credit on my personal income tax return.

____
Employee Signature

____
Employee E-mail Address

____
Date:

Nyhart.com

Submit Claim Form to: Flex Department
NYHART
P.O. Box 80208
Indianapolis, Indiana 46280-0208
or Send E-mail to: flexplans@Nyhart.com

or FAX to: 1-888-887-9961

Expenses to be reimbursed

☐ Health Care
*Expenses must be ineligible or non-reimbursed by medical/dental plan.
*The service must be provided while participating in the plan.
*The claim must be submitted during the claim eligibility period.

Type of Expense	Date Incurred	Amount
Medical		
		$
		$
		$
		$
	Total	$
Dental		
		$
		$
		$
		$
	Total	$
Vision		
		$
		$
		$
		$
	Total	$
Other		
		$
		$
		$
		$
	Total	$

☐ Dependent Care
*Expenses must be ineligible or non-reimbursed by medical/dental plan.
*The service must be provided while participating in the plan.
*The claim must be submitted during the claim eligibility period.

		$
		$
		$
		$
	Total	$

Dependent Care Provider

____
Name

____
Address

____
Tax ID Number or SSN for Individuals

Nyhart.com

Instructions for Filing a Claim

- For medical/dental/vision expense claims that were submitted to a health plan or an insurance company, but were not fully paid by that carrier, **please attach copies of the insurance carrier claim and/or payment form such as an Explanation of Benefits (EOB)** to establish the amount not covered under the medical/dental/vision plan.
- For all other reimbursable expenses, the copies of all bills must be attached. **These list who rendered the service (name and address), the reason for the charge, the amount of charge, and the date.**
- Please be aware cancelled checks alone are not acceptable receipts.
- Please attach receipts to an 8 1/2 X 11 piece of paper when sending.
- PLEASE DO NOT HIGHLIGHT receipts.
- **The Claim Form must be complete, including Participant signature and date.**
- **Please keep original documents for your records and send Nyhart the copies.**

Where to Send a Claim

Mail to: Attn:Flex Department
NYHART
P.O. Box 80208
Indianapolis, Indiana 46280-0208

or Send E-mail to: flexplans@Nyhart.com

or FAX to: 1-888-887-9961

For any questions regarding a claim, call:

Phone: 317-803-7750
Toll-Free: 800-284-8412