Group & Pension Administrators, Inc.
P O Box 749075
Dallas, TX 75374-9075

CAFETERIA PLAN STATEMENT OF CLAIM
FAX # 972-238-7853

GENERAL INSTRUCTIONS

1. Complete ALL questions in parts A, B, C and/or D and E. Refer to the reverse side for a list of eligible expenses.
2. Attach itemized bills and/or receipts to this statement. All bills must contain: (a) the identification of the service provider; (b) name of person services was provided for; (c) dates of service; and (d) itemized services rendered and amount charged for each.
3. Make sure the claim does not include items for more than one plan year. Use a separate claim form for each plan year.
4. If Group & Pension Administrators, Inc. also administers your other medical benefits, you may include a claim form for that as well.
5. If Group & Pension Administrators, Inc. does not administer your medical benefits and this is a claim for medical reimbursement, then also include a copy of your explanation of benefits from your medical plan showing the medical expenses not reimbursed.
6. After receiving a claim, the Claims Administrator will send the Employee an itemized statement explaining covered and non-covered expenses.

PART A – Employer Information

1. Employer Name	2. Plan #	3. Group #
Trinity University	**S860056**	**S860056**

PART B – Employee Information

1. Employee Name (first, middle, last)	2. Birthdate	3. Certificate #

4. Home Address (street, city, state, zip)	5. Social Security #

PART C – Unreimbursed Medical Expense Claims

1. Claim is for: ☐ Self ☐ Spouse ☐ Other Dependent Relationship: _____	2. Patient's Name	3. Sex ☐ Male ☐ Female	4. Birthdate

5. Was the Illness or Injury caused by the result of employment, or in any way work related?	☐ Yes	☐ No
6. Will you or the patient receive or be seeking any monetary recovery from any person or responsible party?	☐ Yes	☐ No

6(a). If 6 is "Yes", give Name and address of responsible party:

7. Is your spouse employed? ☐ Yes ☐ No	7(a). Name of Spouse	7(b). Birthdate	7(c). Social Security #
If "Yes" Complete:	7(d). Name, Address and Phone Number of Spouse's Employer		

8. Are you or your Dependents covered by any other group insurance, prepaid health plan, Medicare, or other government plan?

☐ Yes ☐ No	8(a). Insured's Name		8(b). Other Plan Name
If "Yes" Complete:	8(c). Policy #	8(d). Certificate #	8(e). Other Plan Address (street, city, state, zip)

PART D – Claims Reimbursement Detail

1. Claimant Name (Patient) (Please circle **M** for Medical or **D** for Dependent Care)		2. Dates of Service From	To	3. Provider Name	4. Provider Tax # (Not applicable for Medical)	5. Amount
a.	M / D					
b.	M / D					
c.	M / D					
d.	M / D					

DEPENDENT CARE NOTICE: The total amount claimed under the Plan for any coverage period must not exceed the lessor of your earned income for the plan year or earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of him/herself, then he/she is deemed by the IRS to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the plan if the service provider is your dependent for federal tax purposes, or is your child or step-child and is under age 19.

PART E – Employee Certification

READ CAREFULLY. The undersigned Participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under their Employer's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

1. Date	2. Employee's Signature

Eligible Cafeteria Plan Reimbursement Account Expenses

Only expenses incurred during the plan year can be claimed for reimbursement. Each year is treated separately and the year of claim is the plan year the expense was actually incurred by the Participant. It is a Plan requirement that separate claim forms be used for each year.

Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. Please review your Summary Plan Description.

Allowable expenses are the same as those allowed for federal income tax purposes. A summary list is provided here for your convenience. Be advised, the IRS may revise this list from year to year. Consult IRS Publication 502 for current qualifying medical expenses.

Qualifying Unreimbursed Medical Expenses

Only expenses NOT otherwise reimbursed may be claimed.

- Ambulance hire
- Artificial limbs and teeth
- Automobile Modifications (hand controls, special equipment, mechanical lifts)
- Braille books and Magazines
- Crutches
- Drugs (legal) (prescription only or insulin and medical supplies)
- Elastic hose, Medically prescribed
- Eyeglasses/contact lenses
- Fees:
  - Acupuncture
  - Anesthetist
  - Blood donor
  - Chiropodist
  - Chiropractor
  - Christian Science practitioner
  - Clinic
  - Dentist
  - Diagnosis
  - Diathermy
  - Examination, physical
  - Eye exams
  - Gynecologist
- Health services
- Hospital
- Laboratory
- Lip reading lessons for the deaf
- Medical information plan
- Midwife
- Nurse
- Obstetrician
- Oculist
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Practical nurse
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychopathist
- Sex Therapist
- Surgeon
- Therapy
- X -rays
- Wheelchairs
- Over-the-Counter Purchases (See separate list for approved items)

Qualifying Dependent Care Expenses

Expenses paid to a dependent care center or care provider for:

1. The care of Dependent under age thirteen (13); or

2. The care of other Dependents who are physically or mentally incapable of caring for themselves.

No payment may be made under this Plan if the service provider is your Dependent for federal income tax purposes, or is your child or step-child and is under age nineteen (19).