Administered by
Integrity Administrators, Inc.
P.O. Box 13128 Sacramento, CA 95813-3128 1-800-562-9383 Fax 916-921-3383

The University of Puget Sound

PERSONAL EXPENSE ACCOUNT CLAIM FORM

INSTRUCTIONS- Please type or print. See reverse side for additional important information.

1. Complete Part A.
2. List all expenses in Parts B and C and attach the following documentation:
   - ❑ **Expenses covered by your health care plan**: Medical, vision or dental expenses covered by medical or dental care plans must be submitted under those plans first. Attach a copy of the explanation of benefits statement to claim amounts not paid by your medical, vision, or dental plan.
   - ❑ **All other expenses:** For all other expenses, attach bills that clearly state:
     Name of person receiving the service, amount charged, nature of service or supplies, date service was rendered, name and address of provider of service. **Canceled checks or receipts cannot be accepted.**
   - ❑ **Dependent Care Expenses: Complete** the requested additional information for dependent care expenses, **Secure the care provider's signature on the form or attach a receipt from the provider.**
3. Read Part D carefully and sign.
4. Send this form with supporting documentation to Integrity Administrators, Inc. **Claims submitted without the required documentation cannot be processed and will be returned to you.**

PART A Faculty / Staff Member Information

❑ Check if the address below is new.

Name: ____________________ S.S.No. ____________________

Current Address ____________________

City / State / Zip ____________________ Telephone ( ) ____________________

PART B Health Care Expenses

In the " " column please indicate if these expenses were covered by any insurance , using these coverage codes:
U – University of Puget Sound Sponsored Plan **O** – Other Insurance **B**- Both **N**- None

BENEFIT CODE *	PROVIDER OF SERVICE		SERVICE DATE	AMOUNT
				$
				$
				$
				$
				$
				$
				$
* Benefit Codes: M- Medical D- Dental H- Hearing V- Vision PD- Prescription Drug O- Orthodontia CH- Chiropractic			Total Requested Amount	$

PART C Dependent Care Expenses (CHILD DAYCARE EXPENSES)

BENEFIT CODE *	PROVIDER OF SERVICE	DEPENDENT NAME / RELATIONSHIP	AGE	SERVICE DATE	AMOUNT
DC					$
DC					$
DC					$
DC					$
For Dependent Care Claims, secure the care provider's signature or attach a receipt from the provider.				Total Requested Amount	$

Child Care Provider's Signature	Child Care Provider's Signature
Address	Address
City, State, Zip	City, State, Zip
Tax ID #	Tax ID #
Relationship, if any	Relationship, if any

PART D Please read carefully and sign

I request payment from my Personal Expense Account for the expenses listed above. I certify that I have not, nor will, I request reimbursement under this plan or from any other source for these expenses. I also certify that the total dependent care expenses, if any, for which I am requesting reimbursement this plan year do not exceed the lesser of my or my spouses earned income for the year. I further certify that I have met all the requirements for eligible healthcare and/or dependent care expenses as described on the reverse of this form. I understand that reimbursement expenses cannot be claimed on my personal income tax return.

Employee Signature: X______________________________________ Date: __________________________

Integrity Administrators, Inc. use only

EXPENSES REVIEWED AND APPROVED

Approved by: ____________________

Date Approved: ____________________

Claim No. ____________________

Date Processed: ____________________

PERSONAL EXPENSE ACCOUNT

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

CLAIM FILING INSTRUCTIONS

1. Read the information below.
2. Complete the information on the front side.
3. Enter your expenses in the Claim Information Section on the front side.
4. Dependent Care: Complete the requested additional information for dependent care expenses.
5. Sign and date.
6. Send this form with supporting documents to:

INTEGRITY ADMINISTRATORS, INC.
P.O. BOX 13128
SACRAMENTO, CA 95813-3128

1. HEALTH CARE ELIGIBLE EXPENSES

In general, an employee may be reimbursed for a health care expense which qualifies as a deduction on the Federal Income Tax return, but which has not or will not be reimbursed by any other source and has not been or will not be deducted on the employees income tax return. Some examples of eligible expenses include co-insurance and deductible amounts, vision, hearing, dental, and prescription drug expenses not covered by your health insurance.

2. **SUPPORTING DOCUMENTATION**

The following supporting documentation must be attached to this form:

A. Expenses covered by your Insurance Plan(s): These charges must be submitted under that plan first. Attach a copy of the Explanation of Benefits Statement to claim the amounts not paid by your insurance plan(s).

B. Expenses not covered by your Insurance Plan(s): For these expenses, **attach bills that clearly state:**

1. Name of person receiving the service
2. Nature of service or supplies
3. Name and address of provider of services
4. Amount charged
5. Date service was rendered

C. Dependent Care expenses: Secure the care provider's signature on the form or attach a receipt from the provider.

3. **DEPENDENT CARE ELIGIBLE EXPENSES**

In general, the following rules apply to dependent care expenses:

A. The annual amount submitted for reimbursement cannot exceed the earned income of the lower paid spouse.

B. The expense must be employment related expense for the care of a dependent of the employee who is under age 13 or a dependent who is physically or mentally incapable of caring himself or herself.

C. The payments cannot be made to a person who is claimed as a dependent by the employee.

D. If the services are provided by a dependent care center which provides care for more than six individuals, the center must comply with all state and local laws.