Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

REIMBURSEMENT REQUEST

(Please staple receipts to back of form)

EMPLOYEE INFORMATION (Print clearly)	
Employee Name:	Bates ID #:
Employer:	Plan Year:

DEPENDENT CARE (Child Care, Elder Care)					
Provider Name	Provider SS# or Tax ID#	Services For (Name)	Relationship/Age	Service Dates	Amount
				TOTAL:	

DEPENDENT CARE PROVIDER (If you don't have a receipt, this section must be completed)

Provider's Name _____ Provider SS/Tax ID#: _____

Provider's Address _____

Address City State Zip

I certify that I have provided the services as listed above:

_____ _____

Provider's Signature Date

MEDICAL CARE (You may copy form if needed for additional expenses or attach an itemized list)				
Provider Name	Service/Item Purchased	Services For (Name/Relationship)	Date of Service	Amount
Mileage Reminder	You are eligible to reimbursed for mileage to and from an eligible medical appointment.		Number of miles x $0.19 =	
			TOTAL:	

I request reimbursement for my dependent care expenses and/or medical care as itemized above. Enclosed are receipts which state: date of service, provider name, type of service, and fee charged for the service. My signature below acknowledges my understanding of the following: 1.) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source. 2) The expenses must qualify for reimbursement under the Internal Revenue Code. 3) Reimbursed expenses cannot be claimed as credits or deductions on my personal income tax. 4) Participation in a Medical FSA may disqualify me and/or my spouse from participation in a Health Savings Account. 5) I have retained copies of the documentation submitted with this expense as these materials will not be returned to me.

Signature: **Date:**

SIGNATURE REQUIRED

Reimbursement requests must be received before 12 Noon (ET) on Tuesdays for processing that week. Requests received after this time will be processed the following week.

MAIL TO: Group Dynamic, Inc., Reimbursement Benefits, 411 U.S. Route One, Falmouth, ME 04105
EMAIL TO: claims@gdynamic.com WEBSITE: www.gdynamic.com

FAX TO: Reimbursement Benefits, 207-781-5200 PHONE: (207) 781-8800 or 1-800-626-3539

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