REIMBURSEMENT REQUEST FORM

1. Complete the information below. Be sure to provide all information requested by this Form. If the Form is incomplete, your claim will be denied.
2. Forward completed form to Participant Services:
   Email: ParticipantServices@AssociatedBank.com
   Fax: 920-327-6546
   Mail: Associated Bank, ATTN: MS 7004, PO Box 19097, Green Bay, WI 54307-9097

*Required Fields

Participant Information

*Employer Name (do not abbreviate)

*Participant Name (First, MI, Last)

*Birth Date (MM/DD/YYYY)

*Last 4 Digits of SSN Number

*Participant Mailing Address (cannot be a PO Box)

*City

*State

*Zip Code

Email Address

Day Telephone

Reimbursement Information

Claim Information

*Plan Type[1]	*Did you file this expense on the Participant Portal or through the Mobile App?	*Date(s) Expense(s) Incurred	*Merchant/Provider Name	*Name of Person Receiving Product/Service	*Claim Amount
					$
					$
					$
					$
				Total Reimbursement Requested:	$

[1]Plan Types:
FSA – Flexible Spending Account
DCA – Dependent Care Account
LFSA – Limited Flexible Spending Account
HRA – Health Reimbursement Account

Dependent Care Provider Information (to be completed by the provider)

Dependent Care Provider Signature and Certification (Dependent Care Claims Only)

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your daycare provider must complete this step. If you would prefer to file only one claim for the plan year, please access the Recurring Dependent Care Request Form at https://client.hsaplus.associatedbank.com/.

*Dependent's Name	*Dependent's Date of Birth (MM/DD/YYYY)	*Dependent's Social Security Number	*Service Type (choose one)
		☐☐☐ - ☐☐ - ☐☐☐☐	☐ Child Care ☐ Adult Care[1]
		☐☐☐ - ☐☐ - ☐☐☐☐	☐ Child Care ☐ Adult Care[1]
		☐☐☐ - ☐☐ - ☐☐☐☐	☐ Child Care ☐ Adult Care[1]

[1]If choosing Adult Care as an expense, please submit a Medical Necessity Form if you haven't already.

I certify either myself or my organization has provided care to the dependent(s) identified above. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

*Dependent Care Provider Signature _____ *Date _____

Participant Certification

I certify that the reimbursement request I am submitting is for the purpose of a qualified expense and, where my request includes reimbursement for dependent care, I certify it is for an eligible individual, as set forth by IRS Code and applicable plan documents. I have not been previously reimbursed for these expenses, nor am I seeking reimbursement for these expenses from any other source. I understand that Associated Bank, its affiliates, agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify Associated Bank. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

*Participant Signature _____ *Date _____

Completion Guide

This form is for the reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your debit card must be submitted with a copy of a Receipt Reminder. Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Participant Information

- **E-mail address:** If you would prefer to receive notifications electronically or if your email address has changed, please update your information on the Participant Portal. You can also contact us at 800-270-7719. We have representatives available M-F, 7:00 a.m.- 7:00 p.m. CT.

Reimbursement Information

- **Plan Type:** Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Did you File this expense on the Participant Portal, or through the Mobile App:** If a claim was filed online at https://client.hsaplus.associatedbank.com/ or in the Mobile App, mark "Y" for yes; if not, mark "N" for no.
- **Date(s) Expense(s) Incurred:** Provide the date or range of dates the expenses were incurred.
- **Merchant/Provider Name:** Provide the name of the merchant or facility where the expense was incurred.
- **Name of Person Receiving Product/Service:** Provide your name or the name of the tax dependent for which the service was provided, or the product was purchased.
- **Claim Amount:** Provide the total amount requested for the specified expense.
- **Total Reimbursement Requested:** Total the amounts in the "Claim Amount" boxes.

Dependent Care Provider Signature and Certification

- Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Participant Certification

- Sign and date the form after reading the Participant Certification.

Submit the completed form with the supporting documentation to Associated Bank:

Associated Bank
ATTN: MS 7004, PO Box 19097
Green Bay, WI 54307-9097

Email: ParticipantServices@AssociatedBank.com

Fax: 920-327-6546

Questions? Please call Participant Services at 800-270-7731 (M-F, 7 a.m.-7 p.m. CT).

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received, or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (Please be advised: if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider
- For Adult Care Services, a letter from the doctor or a Medical Necessity Form is required to identify that the dependent is physically or mentally disabled and unable to self-care.

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.