Flexible Benefits Plan

Medical Reimbursement Voucher Form

EMPLOYER NAME: RENSSELAER POLYTECHNIC INSTITUTE **GROUP: 2170**

EMPLOYEE NAME: _____ **SOCIAL SECURITY NO.** ___ — ___ — ____

EMPLOYEE ADDRESS: _____ **(** ___ **)** _____
Number/Street City State Zip Daytime Phone Number

Email: _____ ☐ **Yes, I want to receive my Quarterly Statements and other communications by email**

☐ **Please check if this is a new address.**

☐☐ **For CFH use only**

Instructions:

1. Each expense **must** be itemized on this form and substantiated by a written statement from the provider of the qualifying product or service certifying:
   - The date the product or service was provided
   - A description of the product or service provided
   - The amount charged
   - The name of the provider
   - The name of the person to whom it was was provided

   Important:
   Your claim will be returned unless all of the listed elements are clearly identified on your receipt.
2. **Canceled checks will not be accepted for claim substantiation.** Attach bills, receipts, insurance benefit determinations, and/or attending physician statements.
3. Please be sure to sign and date this form.
4. Please make a photocopy of the reimbursement voucher form and documentation for your records. Your completed Reimbursement Voucher Form and supporting documents must be submitted to the following address, to ensure prompt reimbursement:

   Flex Claims
   Charles F. Herman & Associates, Inc.
   PO Box 13565
   Albany, NY 12212-3565

I a m c l a i m i n g t h e f o l l o w i n g M e d i c a l e x p e n s e s :

OTC Code*	Date of Service	For the Benefit of: (Name and Relationship)	Description of Service	Amount
M E D I C A L E X P E N S E T O T A L				$ 0.00

*** OTC Codes Required – The number or letter corresponding to the OTC Item must be recorded in the OTC Code column**

A. Small quantities, of the following items, do not require a physician's letter to be reimbursed by the plan

1. Allergy Medicine or Cold & Flu Medicine, containing analgesic, antihistamine or antitussive formulation
2. Antibacterial cream
3. Balm for treating muscle and joint pain
4. Burn cream or ointment containing antibiotic
5. Diaper rash ointment
6. Foot preparations containing antifungal
7. Gastrointestinal medicine containing antacid, antiflatulent, antidiarrheal, antiemetic, laxative or fecal softener
8. Hemorrhoid treatment, including suppositories and creams
9. Insect bite medication containing Anti-Infective agent
10. Nicotine gum or patches for stop-smoking purposes
11. Opthalmic preparation
12. Pedialyte or similar formulation for treating an ill child
13. Pain reliever containing aspirin, ibuprofen or acetaminophen
14. Respiratory product containing sympathomimetic
15. Sinus medicine or nasal sinus spray
16. Wart removal medication

Reimbursement for the following items is permitted only if your claim is accompanied by a letter from a licensed physician recommending the use of these items for (1) the treatment of a specific medical condition, not for general health and (2) for a specified time duration. The letter must specify the condition being treated and the duration of the treatment program.

A. Fiber supplements and digestive aids
B. Herbal medicines and vitamins
C. Hormone therapy to treat symptoms of menopause
D. Prenatal vitamins
E. Sedatives and Hypnotics
F. Weight-loss drugs used to treat a specific disease (including obesity). Items that replace normal food consumption are not reimbursable.

Certification

The expenses listed on this form are eligible under the Flexible Benefits Plan. I certify that I have incurred these expenses on behalf of myself or my eligible dependent(s). I will not seek reimbursement from my insurance carrier or any other source and I will not claim these expenses as a deduction or for a credit when filing Internal Revenue Service Form 1040.

Employee Signature: X_____ **Date:** _____