MINT REIMBURSEMENT CLAIM FORM

Please type or print all information

EMPLOYER NAME: (required for processing) _____

Social Security Number: (for security purposes, please provide at least the last 4 digits of your SSN)

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Employee Last Name:

Employee First Name:

Employee Email Address:	**Phone Number:**

HEALTH, DENTAL & VISION EXPENSES

Documentation for each request will need to show **date of service**, **description of service** provided and **charges**, as well as the providers name and address. *IRS regulations do not allow canceled checks, credit card receipts, or bank statements to be used as documentation of expenses.*

- Please itemize your expenses to help ensure proper processing. If you have more expenses than this form allows, please copy this form and attach it. If you need more reimbursement forms please contact us and we will send them to you. If you do not itemize your expenses, we will process your claim based on the documentation received. Please avoid using highlighter on any faxes, as documentation becomes illegible.
- **Active** participants may submit claims at any time during the plan year, but **must** have all claims for a given plan year submitted within 90 days after the end of the plan year. Claim submission periods for terminated participants may vary.
- **Fax**: 844-862-0872; **Email**: MintClaims@FBAofSyosset.com; **Mail**: 333 Earle Ovington Blvd, Suite 510, Uniondale, NY 11553
- For questions, please call **(866) 283-9115**

Date of service	Provider Name or Name of Store	Description of Expense	Amount

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 the period while the undersigned was covered under the Company's Plan; and that the expense has not already been reimbursed. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes which relate to such expense.

Employee's Signature:_____ Date:_____