INDIANA UNIVERSITY
HUMAN RESOURCES

TAX SAVER BENEFIT (TSB) PLAN
REIMBURSEMENT OF PAYMENT REQUEST

File Your Claim Online at ***iu.nyhart.com***

1. EMPLOYEE INFORMATION:

Employee Name: _____ 10-Digit Employee ID: __ __ __ __ __ __ __ __ __ __

Address: _____ City: _____ State: _____ Zip: _____

Campus: _____ Phone: _____-_____-_____ E-mail: _____

❑ 2A. HEALTHCARE EXPENSES:

Claims must include receipts, health claim summaries, bills, and/or checks (photocopies acceptable) supporting your claim. They MUST include the following: **Name of Provider, Type of Service, Date of Service, and Charge of Each Service**. Expenses must be ineligible or non-reimbursed by medical/dental plan, incurred while participating in the plan, and submitted during the claim eligibility period.

Date(s) of Service	Patient Name	Date of Birth	Relationship to Employee	Type of Service	Amount
					$
					$
					$
					$
					$
					$
				TOTAL:	**$ 0.00**

❑ 2B. DEPENDENT CARE EXPENSES:

Expenses must be eligible under this plan, incurred during the plan year, and submitted during the claim eligibility period.

Dependent Name	Date of Birth	Relationship to Employee	Date(s) of Service	Provider Information	Amount
				Name: Address: EIN/SSN:	$
				Name: Address: EIN/SSN:	$
				TOTAL:	**$ 0.00**

3. EMPLOYEE CERTIFICATION:

I hereby certify that the information on this claim form is correct and authorize release of payment through my reimbursement account. I understand that reimbursement is not a guarantee that this payment is tax exempt and I am responsible for any tax consequences resulting from claiming ineligible expenses. I have not received reimbursement for these expenses previously from this or any other plan. The total of any reimbursed dependent care expenses for the plan year does not exceed either my spouse's or my earned income (W-2 pay) for the year. I understand that reimbursed dependent care expenses cannot be used to claim a credit on my personal income tax return. I also understand that submitting false claim information could lead to termination of employment, potential prosecution and possible implications with the Internal Revenue Service (IRS). I understand that the above providers may be contacted to confirm/clarify information related to this claim.

If submitting this form electronically, please be aware that by typing your name in the signature box, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. By signing the agreement, you consent to be legally bound by the form's terms and conditions. You further agree that your use of a keyboard, mouse, or other device to type in the provided boxes, to select an item, button, icon or similar act/action in order to provide information required in completing this form is acceptance and agreement as if actually signed by you in writing.

Employee Signature: _____ Date: _____/_____/_____

Return Form & Documentation to Nyhart, ATTN: Flex Claim Reimbursement, 8415 Allison Pointe Blvd, Suite 300, Indianapolis, IN 46250
Fax (888) 887-9961 **Customer Service** (800) 284-8412

Clear Form Print Form