INDIANA UNIVERSITY

TAX SAVER BENEFIT (TSB) PLAN CLAIM FORM

HUMAN RESOURCES

IMPORTANT INFORMATION—PLEASE READ BEFORE COMPLETING THIS FORM

Claims can be submitted by completing this form or online by logging into your Nyhart account at iu.nyhart.com. DO NOT submit the same claim using both methods (online and paper form).

Healthcare Spending Account: Claims must include a copy of the receipt for the service or purchase, a confirmed online bill payment, or a health claim summary (EOB) from an insurer supporting your claim. Each supporting document MUST include the name of the provider and the type, date, and cost of the service. Expenses must be incurred between January 1 (or the initial date of eligibility) and December 31. Claims must be submitted to Nyhart no later than February 28 of the following year.

Dependent Care Spending Account: Expenses must be incurred between January 1 (or the initial date of eligibility) and March 15 of the following year. Claims must be submitted to Nyhart no later than April 15 of the following year.

SECTION 1 EMPLOYEE INFORMATION

Employee Name:		University 10-Digit ID:	
Address:	City:	State:	Zip:
Email:	Phone:	Campus:	

☐ SECTION 2A HEALTHCARE EXPENSES

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

☐ SECTION 2B DEPENDENT CARE EXPENSES

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

SECTION 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.

Signature:	Date:

Return form and documentation to:

Nyhart, ATTN: Flex Claim Reimbursement, 8415 Allison Pointe Blvd, Suite 300, Indianapolis, IN 46250, or fax to (888) 887-9961

Customer Service:

(800) 284-8412 | support@nyhart.com | iu.nyhart.com