

POLESTAR BENEFITS, INC. – REQUEST FOR REIMBURSEMENT

Company Name		Comments:
Employee Name		
Employee Phone #		
Employee Email		
SEND CLAIMS TO		
Fax	(888) 539-9565	
Email	claims@polestarbenefits.com	
Mailing Address	412 Jefferson Parkway, Suite 202 Lake Oswego, OR 97035	
Please visit www.polestarbenefits.com/downloads.html for additional forms.		
Please list eligible medical, dental, vision services and/or expenses for you and your family that you have not already claimed through Polestar Benefits, Inc. in the appropriate boxes below. <u>Only list the amount of the expense you are eligible for and is not being reimbursed through another Plan, by another Administrator/Carrier.</u>		

REIMBURSEMENT REQUESTED		
List Services for Reimbursement	Reimburse From HRA, FSA, Transit or Dependent Care	Estimated Amount to Reimburse
		\$
		\$
		\$
		\$

***IF ANY EXPENSES WERE COVERED BY INSURANCE, PLEASE SEND THE EXPLANATION OF BENEFITS (EOB)**

*****AS OF 1/1/2011, OVER-THE-COUNTER PURCHASES ARE NOT REIMBURSABLE UNLESS RECOMMENDED IN WRITING BY A MEDICAL PROFESSIONAL TO TREAT A MEDICAL CONDITION*****

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.

I certify that these statements are true and that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed by Polestar Benefits, Inc. may not be claimed on my individual tax return at the end of the year.

Employee Signature:	Date:
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IF YOUR ADDRESS HAS CHANGED. PLEASE LIST BELOW.

NEW ADDRESS	Street/PO Box			
	City	State	ZIP	

If have questions about filing claims, please call Polestar Benefits, Inc. at (503) 946-3298 *in Oregon* (360) 356-1655 *in Washington* (855) 222-3358 Toll Free