CIGNA Choice Fund® Reimbursement Request Form

Use this form to request payment from your:
Health Reimbursement/Incentive Points Account

Please follow these steps to ask us for payment. If you don't fill in all the required information and sign the form, we won't be able to pay you.

1. Read every box. Fill in all the required information on this form. Required information is marked with *.

FOR INTERNAL USE ONLY:
CORR TYPE - RD

EMPLOYEE INFORMATION

*1. CIGNA ID NUMBER OR SOCIAL SECURITY NUMBER	*2. LAST NAME	*3. FIRST NAME	4. M.I.	*4a. DATE OF BIRTH

*5. MAILING ADDRESS	*6. CITY	*7. STATE	*8. ZIP CODE

9. EMPLOYER NAME	*10. ACCOUNT NUMBER(S)
STATE HEALTH BENEFIT PLAN	3330877

2. Please only use one form for each person's expenses.

PATIENT INFORMATION

*11. PATIENT NAME	*12. PATIENT DATE OF BIRTH

3. Important! Please do not write "See attached" or "N/A" in any space.

4. Due to changes in IRS regulations, effective 1/1/2011 Over-the-Counter Drugs require a prescription for reimbursement. Please see page 2 for more information.

ITEMIZED EXPENSES

*13. DATE OF SERVICE OR PURCHASE (MM/DD/YY) *(Only use one date per line)*	*14. AMOUNT REQUESTED FOR REIMBURSEMENT	*15. TYPE OF SERVICE OR PURCHASE 1 = Medical 35 = Dental 88 = Pharmacy 89 = Over-the-Counter Items AL = Vision 81 = Routine Care/Physicals A4 = Mental Health/ Substance Abuse 12 = Incentives 30 = Insurance Premiums 9 = Other	*16. PROCEDURE CODE AND/OR DESCRIPTION OF SERVICE OR PURCHASE	17. NATIONAL DRUG CODE *(Optional)*	*18. HEALTH CARE PROFESSIONAL, FACILITY OR STORE NAME
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				

TOTAL: $ _____

5. Sign your name in Box 19. Without your signature we cannot pay you.

CERTIFICATION AND SIGNATURE

I certify that all expenses for which reimbursement is requested from the CIGNA Flexible Spending Account, Health Reimbursement Account, including Healthy Awards and Healthy Future Accounts, have been incurred and have not been reimbursed and are not reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, an itemized receipt from a merchant or an explanation of benefits from the health care professional. I represent that any individual (other than the employee or employee's spouse) for whom a claim is filed hereunder, qualifies as an eligible dependent of the employee as defined in your FSA plan documents. I further declare that I have not and will not deduct these expenses from my federal, state or local income tax returns.

*19. EMPLOYEE SIGNATURE *(Required - unsigned Reimbursement Request Forms will not be processed and will be returned to you)*	DATE

6. Mail the completed and signed form, along with receipts to: CIGNA, P.O. Box 188050, Chattanooga, TN 37422-8050

7. If you have any questions, call us at the toll-free number on the back of your CIGNA ID card, 24 hours a day/7 days a week.

For more information, see the Frequently Asked Questions on page 2 of this form.

Cat. #844782 06/2011

CIGNA Choice Fund Reimbursement Request Form - Frequently Asked Questions

FILLING OUT THE REIMBURSEMENT REQUEST FORM

1. **How do I know what information is "required"?**
   Required information is marked with an *.
2. **I received services over more than one day, what date do I put in Box 13?**
   Write the first date the service was received.
3. **I have payment requests for more than one person, what do I do?**
   Use a separate form for each person.
4. **Who signs the form?**
   The employee must sign and date the form in Box 19. Without the employee's signature, we can't pay you.

ALL ABOUT RECEIPTS

5. **Must I include a receipt for each service or purchase?**
   You must include a receipt or Explanation of Benefits, for each product or service you list in Box 16.
6. **What information must the receipt include?**
   - **Date of Service** - The date you received the service or purchased the product.
   - **Type of Service or Purchase** - A detailed description of the service or product you paid for.
   - **Name of the Health Care Professional, Facility, or Store**
   - **Amount** - The dollar amount paid for the services or product.
7. **May I send a photocopy of my receipt or Explanation of Benefits?**
   Yes. Both originals and photocopies are acceptable, as long as they include the information listed in Question 6 above.
8. **Are there guidelines I should follow when I prepare and send receipts?**
   Please do the following:
   - Tape store receipts smaller than 8.5" x 11" to a blank sheet of paper, so we can scan it easily.
   - On the receipt, circle the expenses you list on the Reimbursement Form.
   - Do not use a highlighter: We can't see highlighter marks after we scan your receipt.

OVER-THE-COUNTER DRUGS AND MEDICINES THAT NEED A DOCTOR'S PRESCRIPTION

9. **Are there new rules in 2011 due to Health Care Reform?**
   Yes. For most over-the-counter drugs and medicines you buy on or after January 1, 2011, you must include ***both*** a doctor's prescription and a receipt. Without both, we can't pay you. For a complete list of OTC drugs, please refer to your Summary Plan Description (SPD) booklet.

SENDING YOUR REQUEST

10. **Who will receive the payment?**
    By using this form, the employee will receive the payment.
11. **Should I save copies of my request?**
    Yes. Keep copies of the form, receipts and all other documents you send us. You may need them for tax purposes.
12. **Who can I contact if I have questions or need help filling out this form?**
    Please call us at the number on the back of your CIGNA ID card. We're here 24/7.

Mail the completed and signed Reimbursement Request form, with receipts and any other required documents to:
CIGNA, P.O. Box 188050, Chattanooga, TN 37422-8050
Please remember to sign this form before you send it in.

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