

**UNIVERSITY OF MAINE SYSTEM
ADVANTAGE ACCOUNTS CLAIM FORM**

Section I – Employee Information (Please print)

Name: _____ Employee ID # _____

Section II – HEALTH CARE ADVANTAGE ACCOUNT EXPENSES (Minimum \$25.00 total)

A. Expenses covered by health plan, but not fully paid (deductibles and coinsurance expenses): attach the Explanation of Benefits form(s) that you receive from any insurance company or receipted bill if in a HMO, POS, PPO, or other managed care health plan. If you are requesting reimbursement for prescriptions, please attach the pharmacy receipt(s).

Total amount **you** had to pay: \$ _____

B. Expenses not covered by health plan; attach evidence of payment for each expense listed (paid bills, receipts, cancelled checks). Only list expenses that were not covered **at all** by a health plan or insurance.

Payment Made To	Service Provided	Date of Service	Amount Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Grand Total (Part A plus Part B): \$ _____

Section III – DEPENDENT DAY CARE ADVANTAGE ACCOUNT EXPENSES (Minimum \$25.00 total)

Attach paid bills, receipts, canceled checks or other evidence of these paid expenses.

Payment Made To	Taxpayer ID or Social Security Number of Provider(s)	Service Provided	Dates of Service (From/To)	Amount Paid
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total Paid: \$ _____

List recipient(s) of dependent day care:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section IV – EMPLOYEE CERTIFICATION

I certify that the expenses listed above have been incurred and paid by me or submitted to an insurance company and qualify for reimbursement from the Advantage Account program. I further certify that I will not receive reimbursement for these expenses from any other source or declare such expenses as deduction on my personal income taxes.

Employee Signature _____ Date _____

EMPLOYEE: PLEASE KEEP A COPY OF YOUR CLAIM FOR YOUR RECORDS AND FORWARD THE ORIGINAL TO THE UNIVERSITY OF MAINE SYSTEM, OFFICE OF HUMAN RESOURCES, 16 CENTRAL STREET, BANGOR, MAINE 04401-5106 (OR USE CAMPUS MAIL).

FOR OFFICE USE ONLY:

CLAIM # _____ CLAIM # _____ CLAIM # _____ CLAIM # _____