



Administrative Solutions, Inc.
www.abcbenefitsolutions.net
 P.O. Box 410 Toll Free (877) 461-1424
 Decorah, IA 52101 (563) 387-0789
benefits@benefitsolutions.us FAX (563) 387-0682

**Flexible Spending Account
 Claim Form**

I. EMPLOYER NAME: _____ **PLAN YEAR ENDING** _____

II. PARTICIPANT NAME: _____ **SOCIAL SECURITY NUMBER:** ____ - ____ - ____

III. MEDICAL EXPENSE and OVER THE COUNTER MEDICATION CLAIMS Please attach an Explanation of Benefits From your insurance company; or, if not covered by insurance, attach an itemized bill/ receipt that includes all of the information below. *Canceled checks and bills showing a balance only cannot be accepted as documentation.*

Patient Name	Relation to Employee	Date of Service	Description of Service/Name of Medication	Physician, Provider or Merchant	Is there insurance coverage for this service? If so, an EOB is required.	Amount Incurred	Benefit Code (Office use only)
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
TOTAL MEDICAL AND OTC CLAIMS REQUESTED						\$	

IV. DEPENDENT CARE EXPENSE CLAIM Please attach the invoice or statement provided by your service provider showing the information below. *Canceled checks and bills showing a balance only cannot be accepted as documentation.*

Name of Dependent	Relation to Employee	Date of Service	Provider of Service	Provider's Social Security Number	Amount Incurred	Benefit Code (Office use only)
TOTAL DEPENDENT CARE CLAIMS REQUESTED					\$	

V. INDIVIDUAL PLAN PREMIUM REIMBURSEMENT Please attach documentation of premiums incurred.

Member that the Plan Covers	Relation to Employee	Dates of Coverage	Insurance Carrier	Amount Incurred	Benefit Code (Office use only)
TOTAL PREMIUM REIMBURSEMENT				\$	

VI. STATEMENT OF PARTICIPANT (Read Carefully)

The undersigned participant in the plan certifies that the above expenses were incurred during a period while the undersigned was covered under this FLEXIBLE BENEFIT PLAN and that they, their spouse or dependent has received the service/product described above on the dates indicated. In the case of a Medical Reimbursement Request, the undersigned also certifies that the expenses are for medical care and NOT for cosmetic purposes or for general health purposes and that, if a claim for Over the Counter Medications, the items are not toiletries. It is also understood that additional information, possibly including a statement from a medical practitioner, may be required to confirm that the expense is to treat a specific medical condition.

The expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other health plan coverage, including other flexible spending arrangements. The undersigned fully understands that he or she is fully responsible for the sufficiency and accuracy of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed as a proper expense under the plan, the undersigned will be liable for the payment of all related taxes including Federal or State income tax on the amounts paid which relate to such expense. The undersigned further understands that no medical or dependent care expense tax deduction or credit is permitted for amounts for which reimbursement is made. The undersigned has read the *Explanation to Participants* on the reverse side of this form.

 Participant's Signature

() _____
 Daytime Phone #

 Date

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form with the documentation attached to your Benefits Coordinator or directly to Administrative Solutions, Inc.

**** MEDICAL EXPENSE and OVER THE COUNTER MEDICATION CLAIMS ****

Please list and attach the Explanation of Benefits (EOB) from your insurance company or invoices (if the service is not covered by insurance and, therefore, no EOB is available). If you are providing documentation other than the EOB from your insurance company, these documents must be from the third parties who provided the medical services and must show ***the names of the providers, the dates that services were provided, the amounts charged for the services, and a brief description of the services.***

In general, the types of medical services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would allow for the medical and dental expense deduction under Internal Revenue Code Section 213. Some examples include: Medical and dental expenses which are covered but not paid by insurance (deductibles, co-payments), and items allowed by IRC Section 213 that are not covered by your insurance plan (ie., vision and hearing expenses, dental care, routine examinations, prescription drugs. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Revenue Ruling 2003-102 (Sept. 3, 2003) announced that the cost of over-the-counter drugs and medicines may be reimbursed by Medical Flexible Benefit Accounts. The Revenue Ruling states that "reimbursements by an employer of amounts paid by an employee for medicines and drugs purchased by the employee without a physician's prescription are excludable from gross income" under Code Section 105(b). The Revenue Ruling does NOT permit the reimbursement of drugs or medications that are merely beneficial to the general health of an employee or the employee's spouse or dependents such as dietary supplements and vitamins; drugs or medications used for cosmetic purposes; or items considered to be toiletries. Appropriate documentation of the purchase of the items must be provided as well as proof that the item is intended to be used to treat a medical condition.

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached. At any time during the plan year, you may request reimbursement for expenses that may exceed the amount that you have deposited into your Flexible Spending Medical Account. However, your reimbursement cannot exceed the amount that you have committed to contribute for the Plan Year, minus any reimbursements you have already received for the Plan Year. Special rules apply if you terminate employment or otherwise end your participation in the Plan. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of the maximum reimbursement amount.

**** DEPENDENT CARE EXPENSE CLAIM ****

Please list and attach invoices issued by the third parties who provided the dependent care. This documentation must show ***the name and tax identification number of the provider, the dates that services were provided, and the amounts charged for the services.***

In general, the types of expenses for dependent care services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Section 21(b)(2). Expenses must be for dependents under the age of 13 or incapable of caring for themselves. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you make contributions into your dependent care reimbursement account. And, you cannot ask the plan to reimburse you in advance. For example, if you start contributions with the pay period that begins on February 1, on February 2 you can submit a claim for child care given on February 1, but not for care given on January 31 or for care to be given in March.

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached. If your expenses qualify for reimbursement from the Plan, you will be reimbursed for the total of your expenses, but not more than your account balance in the Plan. Your account balance is the total of the contributions you've made into your Dependent Care Flexible Spending Account minus the reimbursements you've received for the Plan Year.

**** INDIVIDUAL PLAN PREMIUM CLAIM ****

If your employer has elected to include an account for individual plan premiums, you may turn in claims for your individual plan premiums on this form. The policy must be one owned by you as an individual and cannot be the health plan premiums of your spouse's plan through another employer. Documentation must be attached showing the insurance plan information including coverage dates, who the plan covers, and the premiums incurred. Claims for premium dollars must be claimed from a separate individual premium plan account and NOT as part of a Medical Reimbursement account Claim.

**** STATEMENT BY PARTICIPANT AND SIGNATURE ****

Besides providing the information that is needed to prove that your claim is for qualified for reimbursement, you must sign this form on the reverse side. You are thereby swearing that you have not and will not submit the expenses claimed for reimbursement from another Flexible Benefit Plan or use these same expenses in order to receive a tax deduction or credit on your annual income taxes.

** Invoices Must be Attached ** Total Amount Requested ** Participant's Signature Required**
