

# Flexible Spending Account and Dependent Care Reimbursement Request Form

<b>Employer Name</b>	<b>Work Phone</b>	<b>Home Phone</b>	<b>E-mail</b>
<b>Last Name</b>	<b>First Name</b>	<b>M.I.</b>	<b>Social Security Number</b>
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

**Health Care Expenses:** Complete the information below for medical expenses incurred by your or your eligible dependents and attach a Copy of the itemized bill, receipt or EOB (explanation of benefits) from your provider or insurance carrier.  
**IMPORTANT:** A cancelled check or Charge Card Receipt does not satisfy the claims substantiation requirement as provided in IRS Code section 125 Q/A-7(b)(5) and will not be accepted.

Person Receiving Service	Date of Service (mm/dd/yy)	Providers Name	Amount of Expenses
<b>Total Expenses Submitted:</b>			

**Dependent Care Expenses** – Your dependent care provider must sign this form verifying charges incurred OR you must submit a receipt from the provider with the following information.

**Note:** Under dependent childcare regulations, **an expense is incurred when the service is provided, not when you pay for it.** Services must be provided during the plan year and the money withheld from your paycheck prior to being reimbursed.

**If you are not submitting a receipt, complete the information below and have your dependent care provider sign. Be sure to include the providers Social Security Number or Federal Tax ID.**

Name of Dependent	Provider Name	Provider SS#/Tax ID	Dates of Service (mm/dd/yy)	Amount of Expense
<b>Total Dependent Care Expenses Submitted:</b>				

**CLAIM IS NOT BEING REIMBURSED BY INSURANCE OR EMPLOYER (click box)**

To the best of my knowledge and belief, my statements in this reimbursement request form are complete and true. I certify that I or my eligible family member received the services described above on the dates indicated, that the expenses qualify as valid medical/dependent care services Under the plan. If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent under the plan. I certify that I have not been previously reimbursed for these expenses. I certify that these expenses have not been reimbursed, and are not reimburseable under the major medical plan or any other health plan established by my employer such as and HSA or HRA, or my spouse's plan. I will Assume all responsibility for any taxes or penalties arising out of any disallowed deductions. Dependent care expenses: I agree to file IRS form 2441 with my tax return and provide any taxpayer identification number required thereon.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan services provider, files a statement of claim Containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

**Submit Claims To:**  
**Mike Edwards Benefit Group Inc.**  
**4453 Willow Bend Dr.**  
**Gardendale, AL 35071-2367**  
**Fax: (205) 631-8913**

## Qualifying Expenses

The Salary Reduction Cafeteria Plan document contains the rules governing what expenses are and are not reimbursable. Below are some examples to give you a general idea of what items are and are not reimbursable. Please see the Plan Administrator if you have any questions about whether a particular expense is reimbursable.

### Examples of expenses for which you may be able to receive reimbursement include:

- Out of Pocket medical and dental expenses incurred during the plan year and as defined in Code § 213 unless excluded in Plan Document.
- Deductibles and copayments that you are responsible for under our primary medical/dental plan unless excluded by plan document.
- Prescription drugs unless excluded by plan document.
- Eye exams, eyeglasses, contact lenses, and other vision expenses.
- Orthodontic and dental expenses (unless cosmetic)
- Hearing exams, hearing aids, other hearing expenses
- Physical therapy (not massage therapy)
- Payments to a treatment center for alcoholism
- Chiropractics
- Acupuncture
- Stop-smoking programs (but not over the counter smoking cessation aids such as Nicorette)

### Exclusions: The following expenses are not reimbursable:

- Over-the-counter drugs and pregnancy kits (Unless your employer has incorporated reimbursement of over-counter-drugs in the plan)
- Health insurance premiums that you or your spouse pay for coverage under another health plan.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework)
- Massage therapy
- Expenses for weight loss programs or treatments, including prescribed or over-the-counter drugs.
- Home or automobile improvements
- Custodial Care
- Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods
- Health club or fitness programs
- Social activities, such as dance lessons (even though recommended by a qualified physician)
- Bottled water
- Maternity Clothes
- Diaper service or diapers
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed
- Uniforms or special clothing, such as maternity clothing
- Automobile insurance premiums
- Transportation expenses of any sort, including transportation expenses to receive medical care
- Psychotherapy
- Marijuana and other controlled substances, even if prescribed

## Certificate of Qualifying Dependent Care Expenses

By signing and submitting the Dependent Care Reimbursement Portion of this form, you are certifying that expenses for which you request reimbursement meet all of the following conditions:

1. The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year for which the election applies.
2. The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of self-care.
3. The amount of the reimbursement requested, when totaled with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of  
(A) your earned income; or  
(B) if you are married, your spouse's actual or deemed earned income (see below)  
(Your spouse if deemed to have monthly earned income of \$200 (\$400 if you are incurring dependent care expenses for more than one dependent), if your spouse either is a full time student or is physically or mentally incapable of self-care.)
4. Each dependent for whom you incur the expense is  
(A) a person under the age of 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your dependent if you have custody of the child, even if not entitled to claim the dependency exemption), or  
(B) your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
5. You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(A) or 4(B) above.
6. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
7. The expenses are not paid for services outside your household at a camp where the dependent stays overnight.