Fringe Benefits Management Company

PLAN YEAR _____

FLEXIBLE SPENDING ACCOUNT • REIMBURSEMENT REQUEST FORM

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.
PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF THIS FORM

A. NAME _____ HOME PHONE ( ) _____ DAY PHONE ( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NO. _____ EMPLOYER _____

B. MEDICAL CARE ASSISTANCE PLAN

SUMMARY OF EXPENSES				DATES SERVICE PROVIDED		
Name of Person Receiving Service	Relationship to Employee	Provider of Services (Ex.: Hospital, Doctor/Dentist, Drugstore, Medical Supply Store)	Co-Pay	From Mo/Day/Yr	To Mo/Day/Yr	**Amount to Be Reimbursed**
					TOTAL	

C. DEPENDENT CARE ASSISTANCE PLAN

SUMMARY OF EXPENSES				DATES SERVICE PROVIDED		
Name of Person Receiving Service	Relationship to Employee	Age and Grade	Name and Address of Person or Facility Providing Dependent Care Services	From Mo/Day/Yr	To Mo/Day/Yr	**Amount to Be Reimbursed**
					TOTAL	

SIGNATURE OF DAY CARE PROVIDER LISTED ABOVE: _____

Separate receipts are not required if your dependent care provider signs this form after you have completed and signed it. Separate receipts must be attached to this form if your dependent care provider does not sign this form.

I understand, agree and certify to the following:

- I will use my FSA to only pay for IRS-qualified expenses, permitted under my Employer's FSA plan(s), provided to me and my IRS-eligible dependents, on the date(s) indicated above as being incurred within my period of coverage during the plan year.
- I will request reimbursement only after the services have been provided.
- I have not and will not seek reimbursement through any other source, and will exhaust all the other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my FSA.
- I will collect and maintain sufficient documentation to validate my reimbursed FSA expenses.
- I will not claim any reimbursed FSA expense for any federal income tax deduction or credit.
- I specifically release my Employer and FBMC from any liability resulting from either my participation in any FSA or for any misrepresentation I make regarding my requests for reimbursement.
- If I participate in my Employer's Dependent Care Assistance Plan, I will file a Form 2441 with my income tax return and provide any taxpayer identification number required.
- The dependent care expenses I submit for reimbursement were incurred to allow me and my spouse (if married) to work or actively look for work. My spouse is considered working (i.e., gainfully employed) if he or she is a full-time student for five months during the calendar year at an educational organization, or is physically or mentally incapable of self-care.
- I have read and understand the information on the front and back of this form.

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

PARTICIPANT'S SIGNATURE: _____ **DATE:** _____

IL-06-04

INSTRUCTIONS FOR FSA REIMBURSEMENT

(To assure the quickest turnaround and best service, please read these instructions carefully.)

General FSA Reimbursement Request Instructions

- Contact FBMC Customer Service by e-mail at: **webcustomerservice@fbmc-benefits.com**, or call 1-800-342-8017 to request information or assistance.
- **FSA Reimbursement Request Forms will be returned unprocessed if the instructions on this form are not followed.**
- Refer to your Employer's current plan year Enrollment Booklet for information on participation rules, expense eligibility, type of supporting documentation required, and other guidelines.
- To request reimbursement of an eligible FSA expense, supporting documentation is required with your reimbursement request and described further in the instructions under each section below.
- You must maintain copies of the information and documentation you submit for all reimbursed FSA expenses to respond to any IRS inquiries you may receive.
- Cancelled checks and charge receipts (or copies) are not acceptable receipts by the IRS to support the reimbursement of FSA expenses.
- You may not request reimbursement until services have been provided, regardless of when you paid for the service.
- IRS regulations provide that any unused funds that remain in an FSA after a plan year ends (and all reimbursable FSA requests have been submitted and processed) cannot be returned to you nor carried forward to the next plan year but will be forfeited to your Employer.
- If dates of provided services begin in one plan year and end in the next plan year, and you are enrolled in the FSA both plan years, you must submit a separate FSA Reimbursement Request Form for each plan year in which the services were provided.
- Information on any grace period within which you may submit eligible FSA expenses incurred during your period of coverage within a plan year can be found in the "FSA Guidelines" section in your Employer's current plan year Enrollment Booklet.
- Your supporting documentation must be legible.
- You must read over your FSA Reimbursement Request Form to ensure that you have signed, dated and completed it, and attached any required supporting documentation.
- You may access your personal FSA information or request FSA Reimbursement Request Forms, 24 hours each day, by calling FBMC's Interactive Benefits Information Line at 1-800-865-3562.

Additional Medical Care Assistance Plan Reimbursement Request Instructions

- Make sure you complete Section B in its entirety.
- To request reimbursement of an eligible MCAP expense, the following minimum supporting documentation is required: a copy of a receipt, invoice or bill from the provider showing the date service(s) were received, the cost of the service(s), the type of service(s) incurred, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
- Caution: IRS Pub. 502 is intended to help you decide what expenses are *deductible* on Schedule A to IRS Form 1040. No portion of IRS Pub. 502 should be relied upon to help you decide what expenses are reimbursable under an MCAP plan.
- The IRS requires the complete name of all drugs be obtained and documented on pharmacy receipts.
- If the medical coverage is not provided through an HMO, you must attach an Explanation of Benefits (EOB) from the health insurance provider showing the date service(s) were received, the cost of the service(s), the type of medically necessary service(s) received, the name of the IRS-eligible person(s) for whom the service(s) were provided, and any uninsured portion of the cost.
- Some capital expenditures may qualify as medical care under IRC § 213. General rules for capital expenditures that could be reimbursable are: (i) a special version of an otherwise personal item can be reimbursed to the extent of the increased cost; (ii) an item permanently attached to a dwelling can only be reimbursed to the extent that its cost exceeds the increase in value; (iii) if there is no personal element and the item is not attached to a dwelling, it must only be used by the person for whom the medical need has been determined; but (iv) if the item is used by others as well, only a prorated amount of the entire cost can be reimbursed.
- Reimbursement of the cost of certain capital expenditures may require (i) a Letter of Medical Need from the treating healthcare provider, (ii) a personal use letter signed by the patient, and (iii) a capital expense appraisal letter.[1]
- Some provided medical treatments and services, including those that could be deemed personal or cosmetic, require a Letter of Medical Need from the treating healthcare provider.[1]
- The standard mileage rate reimbursable for use of an automobile to obtain medical care is subject to IRS change annually.[1]

[1]*Visit FBMC's Web site at* ***www.fbmc-benefits.com****, or contact FBMC Customer Service by email at:* ***webcustomerservice@fbmc-benefits.com****, or call FBMC Customer Service at 1-800-342-8017 for more information or to obtain letter samples.*

Additional Dependent Care Assistance Plan Reimbursement Request Instructions

- Make sure you complete Section C in its entirety.
- To request reimbursement of an eligible DCAP expense, you must submit a copy of a receipt, invoice or bill from the provider showing the name and address of the provider showing the beginning and ending dates of the provided services, the cost of the service(s), the age and grade, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
- Dependent care expenses must be provided to allow you and your spouse (if married) to work or actively look for work. Your spouse is considered working (i.e., gainfully employed) if, among other requirements, he or she is a full-time student at an educational organization, or physically or mentally incapable of self-care.
- Reimbursement can only be made for eligible expenses incurred for the dependent care of one or more qualifying individuals who reside in your household, at least eight hours a day.
- A qualified person is your tax dependent age 12 or younger, or your spouse or tax dependent who is physically or mentally incapable of self-care.
- FBMC is unable to issue payment on approved reimbursement requests until after the last date of service for which you are requesting reimbursement.
- For timely processing of your request, your payroll contributions must be current.
- The amount of reimbursement requested on this form, added to the dependent care expenses reimbursed to date from any other source or plan, cannot exceed the statutory limits based upon your tax filing status.
- Payments for dependent care cannot be made to you, your spouse, or someone you or your spouse claim as a tax dependent.
- Educational expenses incurred for a child in kindergarten and up are not reimbursable. The cost of dependent care before and after school is reimbursable.
- Tuition is not a reimbursable expense.
- Expenses such as registration fees, activity fees, books, supplies and meals are not reimbursable.

Mail only the *white* copy:

Fringe Benefits Management Company (FBMC)
Post Office Box 1810
Tallahassee, FL 32302-1810
Customer Service: (800) 342-8017 Fax: (850) 514-5817
Interactive Benefits Information Line: (800) 865-3262

If you fax your reimbursement request to FBMC, retain a copy for your records. Do not mail the copy of your faxed transmittal to FBMC.