

Reimbursement Request Form

Instructions: Please complete this form in its entirety to request reimbursement of expenses incurred by you and/or your eligible tax dependents. An example of a completed claim and information regarding reimbursable expenses is provided on the back of this form.



Employee Information

Participant ID#: - -

(or Social Security #)

Zip Code:

Daytime Phone: - -

E-mail Address: _____

Employee Name: _____

Check here if new e-mail address

Employer Name: _____

Claim Information

Plan Benefit Codes		
Health Care	Dependent Care	Transportation
01 Medical 03 Vision 07 Parking/Mileage - Medical 23 Over-the-Counter (OTC)	02 Dental 08 Prescription (RX) 04 Dependent Care	05 Mass Transit 06 Parking at Work

Itemized, third-party documentation must be provided for each expense, including over-the-counter drugs or medications. The "Service Provider Signature" may be substituted for itemized, third-party documentation for expenses (with the exception of over-the-counter medications and drugs). For dependent care claims, if the "Service Provider Signature" is substituted for itemized, third-party documentation, a "Tax Identification Number" or the Provider's social security number must accompany the "Service Provider Signature".

1. **Benefit Code** **Service Start Date** - - 2 0 **Service End Date** - - 2 0 **Amount** \$, .

Detailed Description of Service _____ Person Receiving Service _____ Dependent Age _____ Service Provider Signature and Tax ID # (refer to above instructions) _____

2. **Benefit Code** **Service Start Date** - - 2 0 **Service End Date** - - 2 0 **Amount** \$, .

Detailed Description of Service _____ Person Receiving Service _____ Dependent Age _____ Service Provider Signature and Tax ID # (refer to above instructions) _____

3. **Benefit Code** **Service Start Date** - - 2 0 **Service End Date** - - 2 0 **Amount** \$, .

Detailed Description of Service _____ Person Receiving Service _____ Dependent Age _____ Service Provider Signature and Tax ID # (refer to above instructions) _____

4. **Benefit Code** **Service Start Date** - - 2 0 **Service End Date** - - 2 0 **Amount** \$, .

Detailed Description of Service _____ Person Receiving Service _____ Dependent Age _____ Service Provider Signature and Tax ID # (refer to above instructions) _____

5. **Benefit Code** **Service Start Date** - - 2 0 **Service End Date** - - 2 0 **Amount** \$, .

Detailed Description of Service _____ Person Receiving Service _____ Dependent Age _____ Service Provider Signature and Tax ID # (refer to above instructions) _____

Signature

I request reimbursement from my health care, dependent care, or transportation expense account. I certify that these expenses are not eligible for reimbursement under any other plan and comply with the requirements of the plan. I have not and will not claim these expenses for tax credit or deduction purposes on my income tax return. I hereby certify that any claims submitted under this form pertain to eligible participants and/or eligible tax dependents as defined under the plan and applicable law. I acknowledge that transportation expenses claimed were incurred solely for the purpose of commuting to and from work and parking while at work. For dependent care expenses, I certify that, to the extent required by federal law, I will complete IRS Form 2441 by April 15 of the year after expenses were incurred indicating the name, address, and taxpayer identification number of the provider of these dependent care services. All information provided by me is true and correct and may be relied upon by the administrator.

Employee Signature: _____

Date: _____

* FSA201A *

Fax completed forms to:
763-278-4004
866-278-4004

Mail completed forms to:
Acclaim Benefits
P.O. Box 47338
Minneapolis, MN 55447-0338

Contact Acclaim Benefits:
763-278-4312
800-333-3724
www.acclaimbenefits.com

Completed Reimbursement Request Example

Benefit Code	Service Start Date	Service End Date	Amount
0 2	0 6 - 1 4 - 2 0 0 5	0 6 - 1 4 - 2 0 0 5	\$ 3 0 0 . 0 0
Tooth Extraction	Jonathan	16	James Anderson, DDS
<small>Detailed Description of Service</small>	<small>Person Receiving Service</small>	<small>Dependent Age</small>	<small>Service Provider Signature and Tax ID # (refer to above instructions)</small>

REMINDERS ABOUT REIMBURSABLE EXPENSES SEE YOUR SUMMARY PLAN DESCRIPTION (SPD) FOR ADDITIONAL INFORMATION AND PLAN AVAILABILITY

HEALTH CARE ACCOUNT

- 1) You can use the Health Care Account for the reimbursement of eligible expenses not paid in full by another plan or not covered by your health plan. To be eligible, expense must meet the following criteria:
 - a) Directly related to a physical or mental condition.
 - b) Incurred on or after the effective date of the plan and while you are a participating employee of the plan.
 - c) Incurred by you, your spouse or another person who qualifies as an eligible dependent for federal income tax purposes.
 - d) The expense must be for services already received. Reimbursement cannot be for future or projected services.
- 2) Examples of eligible expenses include:
 - a) Deductible (the part of covered expenses you pay before your health plan pays any benefits).
 - b) Co-insurance amounts (the percentage of covered expenses you must pay, if any, after the deductible requirement has been met.)
 - c) Routine dental procedures (non-cosmetic).
 - d) Vision care expenses, such as eye examinations and eyeglasses.
 - e) Hearing care expenses, including hearing examinations and hearing aids.
 - f) Routine physical examinations.
 - g) Prescription drugs.
 - h) Over-The-Counter drugs and medications if allowed under your plan (refer to your SPD).

DEPENDENT CARE ACCOUNT

- 1) In order for your dependent care expenses to qualify for reimbursement from the Dependent Care Account, the following requirements must be met:
 - a) If you are married, your spouse must be working for pay, attending school or seeking employment while you are at work.
 - b) The children receiving day care must be under the age of 13 at the time day care services are provided, or the person receiving care must be physically or mentally incapable of self-care.
 - c) The provider cannot be listed as a dependent on your federal income tax form, and, if the provider is your own child, must be at least 19 years of age.
 - d) Day care providers must comply with all applicable state and local regulations, including licensing where applicable.
 - e) Expenses must be incurred on or after the effective date of the plan and after the date you become a plan participant.
 - f) Under federal law, when you file your income tax return with the IRS you must also report the name, address, and taxpayer identification number for all providers of dependent care services whose fees were reimbursed to you under this plan during the year. Failure to do so constitutes tax fraud unless the provider of these services is a 501(c)(3) tax-exempt organization. If you have questions on how this might affect your tax filing, contact your tax advisor.
 - g) The expense must be for services already received. Reimbursement cannot be for future or projected services.
- 2) If the amount of the dependent care expense reimbursement you receive for a calendar year exceeds your earnings (if you are single) or the earnings of the lower paid spouse (if you are married), the difference must be reported as taxable income for the year. Special rules apply if your spouse is a full-time student or is physically or mentally incapable of self-care. Consult your tax or legal advisor for more information.
- 3) If there is not enough money in your Dependent Care Account to fully cover the eligible expenses listed on this form, you will be reimbursed up to the amount of your account balance. Additional reimbursements due to you will be temporarily suspended. Suspended amounts will be automatically reimbursed each time contributions are deposited in your dependent care account.

TRANSPORTATION ACCOUNT

- 1) You can use the Transportation Plan to pay for your eligible transportation expenses that meet the following criteria:
 - a) Transportation expenses incurred during your commute to and from work if allowed under your plan.
 - b) Parking expenses you incurred while at work.
- 2) Documentation of eligible expenses must accompany your Reimbursement Request Form. There are two ways you can provide documentation of your transportation expense:
 - a) The provider may complete the Service Provider Signature line on the form, or
 - b) You may attach an itemized statement from the provider.