

Flexible Spending Account Request for Reimbursement



Company: _____

Plan Year: _____

Employee Name	Employee ID No.
Home Address <input type="checkbox"/> Check here if new address	
E-Mail Address <input type="checkbox"/> Check here if new address	Daytime Phone #

Unreimbursed Medical Expenses			
<ul style="list-style-type: none"> Complete this section for unreimbursed qualified medical expenses incurred by you, your spouse or dependent Attach receipt, statement or insurance carrier Explanation of Benefits (EOB) for each item listed Receipt/statement /EOB must list: <ul style="list-style-type: none"> Provider name Date(s) of service (s) Description of service(s) Your portion of the cost Expenses are reimbursable based on date the service occurred and not when you pay for, or are billed for the service. For vitamins or supplements, submit receipt and doctor's note stating the specific medical condition being treated and recommending the specific vitamin or supplement for treatment of that condition. The note should also state if the vitamin or supplement is to be taken for a limited time or indefinitely. Canceled checks are not sufficient as proof of an incurred expense 	Date(s) of Service	Physician or Other Provider	Expense Amount
Total Amount Requested			

Dependent Care Expenses			
<ul style="list-style-type: none"> Complete this section for unreimbursed qualified dependent care expenses which were incurred so that you (and if married, your spouse) can work. Attach a receipt or statement from your dependent care provider <u>or have your provider sign below.</u> Your receipt or statement must list: <ul style="list-style-type: none"> Provider's name Date(s) of service (s) Description of service(s) Your portion of the cost Prepaid expenses cannot be reimbursed until the services have occurred. You will need the provider's name, address, SS# or TIN when you file your Form 2441 with your 1040 at tax time. Canceled checks are not sufficient as proof of an incurred expense. 	Date(s) of Service	Provider	Expense Amount
Total Amount Requested			

Dependent Care Provider Signature (If no receipt is provided)	
I certify that the above listed Dependent Care charges have been incurred.	
Provider Signature	Date

Participant Statement	
I certify that the expenses listed above have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of knowledge all expenses listed above are eligible for reimbursement under the plan. I certify that any prescription drug expenses submitted are for medical care and not cosmetic purposes (e.g., Propecia for male pattern baldness, Retin-A for smoothing wrinkles, etc.). I understand that I am responsible for the accuracy of the information related to this request. I have not and will not seek to be reimbursed through any other health plan coverage and/or dependent care assistance plan for any of the expenses listed above. I further declare I will not deduct any of the reimbursed medical expenses listed above from my federal, state or local tax returns.	
Participant signature	Date

<p>Please email, mail or fax claim forms to: claims@hfsbenefits.com Claims Department, HFS 164 Lakefront Drive, Hunt Valley, MD 21030 Phone: 410.771.1331 / Toll Free: 888.460.8005 Fax: 410.771.5533 / Toll Free 888.510.4218 ****PLEASE DO NOT MAIL ORIGINALS****</p>	<p>Have you visited www.hfsbenefits.com?</p> <ul style="list-style-type: none"> <u>ACCESS YOUR ACCOUNT BALANCE</u> Frequently Asked Questions View A-Z list for eligible expenses Submit Questions
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Explanation to Participants

Medical Flexible Spending Account

1. You must submit all covered health expenses to your and/or your spouse's health insurance carrier before you submit a claim for FSA Reimbursement. When you receive an Explanation of Benefits from your insurance carrier, you may submit the EOB for reimbursement.
2. For expenses not covered under any benefit plan, (such as eyeglasses), an itemized bill must be presented that indicates the date of service, procedure, and the amount you were responsible for.
3. A canceled check or credit card receipt is not a valid form of documentation.
4. Please remember that claim reimbursement is determined by the date of service not the date paid. Therefore, the date of service must always fall within the applicable plan year.
5. If you prepay a service, the reimbursement can be requested after the service has been incurred.
6. In general, the types of medical services that can be reimbursed by the Plan are the same types of expenses that the Internal Revenue Service would allow for the medical and dental expense deduction under Internal Revenue Code Section 213. Please refer to the Summary Plan Description for a more complete explanation of qualified expenses.
7. 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 medical account. However, your reimbursement will not exceed your annual election. Special rules apply if you terminate employment or otherwise end participation in the Plan. (see Summary Plan Description).
8. Domestic partner expenses are not reimbursable through the Medical Flexible Spending Account unless the domestic partner otherwise qualifies as the participants' dependent as defined by the IRS.

Dependent Care Spending Account

1. Your dependent care provider must sign this form verifying charges incurred or you must submit a receipt from the provider for services rendered.
2. If you prepay for a service, such as a summer camp, the reimbursement can be requested after the service has been incurred.
3. You are required to provide the name, address, and tax id # or social security # of your dependent care provider when you file your income tax return.
4. You will be reimbursed up to your current contribution into the Plan. Any balance will be reimbursed as you continue to contribute to the Plan.
5. 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 Code would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Section 21 (b)(2). Please refer to the Summary Plan Description for a more complete list of qualified expenses.
6. Domestic partner expenses are not reimbursable through the Dependent Care Spending Account unless the domestic partner otherwise qualifies as the participants' dependent as defined by the IRS.