

FLEXIBLE SPENDING PLAN REQUEST FOR REIMBURSEMENT

IMPORTANT: Please complete all information on this form. Include only Out-of-Pocket costs for expenses incurred during the Plan Year (see instruction #4 on page two). Attach original receipts and mail to The Employer Group. You will be reimbursed on your paycheck following approval of this request.

EMPLOYEE INFORMATION: <i>Please complete all information to expedite your claim</i>					
Employee Name		Social Security Number		Client Company	
Employee Address (Street, City, State, Zip)					
MEDICAL CARE EXPENSES (not Over-the Counter):			Please attach proof of payment including date of service, amount of payment, and date of payment (copies of checks are <u>not</u> considered acceptable proof of an expense).		
Name of Individual Incurring Expense		Type of Expense		Date Service was Incurred	Out-of-Pocket Cost
OVER THE COUNTER MEDICAL CARE EXPENSES:			Please attach receipt showing name of product purchased, date of purchase and cost. Items that may be used for reasons other than a specific medical condition may require additional information in order to be processed.		
Name of Individual(s) Utilizing Purchased Item		Item Purchased	Quantity	Medical Reason for Purchased Item	Date Item Purchased
DEPENDENT CARE EXPENSES:			Please attach proof of payment (copies of checks are <u>not</u> considered acceptable proof of an expense).		
Day Care Provider		Day Care Provider ID Number		Dates Service was Incurred	Out-of-Pocket Cost
INDIVIDUAL INSURANCE PREMIUM:			You must attach a copy of the independent insurance premium billing. This is not for reimbursement of group insurance premiums paid through your employer.		
Type of Insurance		Name of Provider		Dates Covered	Out of Pocket Cost
EMPLOYEE STATEMENT					
I hereby certify that the information contained in this form is to the best of my knowledge true and correct, each item of expense is eligible for reimbursement and that the expense has not and will not be reimbursed by any other party. I understand that I am responsible for providing proof to support a reimbursed expense and any reimbursed expense later discovered to be NOT eligible for reimbursement will be taxable to me.					
X					
Employee's Signature				Date	

RETURN TO: The Employer Group
 Attn: Flex Reimbursement
 P.O. Box 44759
 Madison, WI 53744-4759

Phone: 800-406-9675

HOW TO FILE A FSA REQUEST FOR REIMBURSEMENT

1. Complete the reverse side of this form, being sure to sign and date it. Failure to complete all areas can result in a delay in processing and claim reimbursement. Your completed form and supporting documents must be mailed to The Employer Group, Attn: Benefits Administrator, P.O. Box 44759, Madison, WI 53744-4759.
 2. Attach itemized receipts that show
For Standard Medical and Dependent Care:
 - Name of person receiving service
 - Nature of service or supplies furnished and charged for each item
 - Date(s) of service
 - Name of provider(s)For Over-the-Counter Medical:
 - Name of item purchased
 - Name of store where purchased
 - Date of purchase
 3. Explanation of Benefits could be used to show date of service, but not provide proof of payment, for standard medical expenses.
 4. Expenses may be incurred during the Plan Year and until March 15 of the following year. The deadline for submitting reimbursement requests is April 30 following the Plan Year in which expenses were incurred (including the two and one-half month extension for incurring expenses following the Plan Year).
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QUALIFYING EXPENSES

To qualify for reimbursement, expenses must be incurred during the Plan Year for which you are requesting reimbursement.

1. **Medical Care Account** – can be used for medical expenses for you or your family that are not covered by any other health plan. Items covered include, but are not limited to:
 - Deductibles
 - Coinsurance
 - Prescription Medication Co-pay
 - Medical, Dental and Vision Services
 - Glasses and/or Contacts
 - Hearing Exams or Aids
 - Over-the-counter medications used to treat specific medical conditions and not for overall health or preventive purposes
 2. **Dependent/Child Care Account** – reimburses for care of your child or other dependent while you are at work. Services may be from one of the following:
 - Day Care Services. Be sure to attach a copy of a paid receipt showing the payments for which you are requesting reimbursement. You must have previously furnished The Employer Group with evidence that indicates that the day care center complies with all applicable state or local laws if it is a facility that provided care for more than six children (not including those who live at the facility).
 - Payment to Employees. Form 942 must be provided. (Form 942 is a quarterly tax return for household employee's social security and withheld income tax.)
 - Payments to Independent Contractors. Be sure to attach receipts showing payments for reimbursable expenses under the plan to independent contractor who are not your employees.
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Refer to your Summary Plan Description for complete details regarding the Flexible Spending Account and reimbursement requirements. If you should have further questions or concerns, please don't hesitate to contact The Employer Group at (608) 845-3377 in the Madison area or toll free at (800) 406-9675.