REQUEST FOR REIMBURSEMENT

INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM MAY DELAY THE PROCESSING OF YOUR CLAIM. Complete all personal information in **Part I**. Complete all claims information in **Part II.** Indicate the type of expense (Medical, DayCare or other), the incurred date(s) of the expense, a brief description (i.e. Orthodontia, Prescription, Dental, Office Visit, OTC, etc.) *(See back of this form for additional examples.)* Attach **COPIES** (do not send originals) of documentation that will prove the **incurred date/service date (not paid date)** and service type that is eligible. Explanation of Benefits (EOB), billing statements, co-pay receipts, cash register receipts, etc. should be submitted for each expense. Received on account receipts, balance due statements, and cancelled checks are **NOT** acceptable forms of proof as they don't verify the date of service and the type of service. **If you are submitting more than one expense, number the copies to correspond to the line number on this form.** Please read **Part III** below and **SIGN** the claim form, attach copies of the proper documentation, and forward by fax **OR** by mail **(not both)** for processing.

PART I EMPLOYEE INFORMATION

PLEASE PRINT

Social Security Number _____ - ___ - _____ Check if New Address _____

Name _____ Wk Phone _____

Address _____

City _____ ST ____ ZIP _____

Employer _____

PART II REIMBURSEMENT INFORMATION

TYPE CODES : M = Unreimbursed Medical/Dental/Optical **D** = Daycare **O** = Other Eligible Expense

TYPE CODE	SERVICE DATE(S) FROM - TO	AMOUNT	PROVIDER NAME/ DEPENDENT NAME	OFFICE USE
1. _____	_____-_____	_____	_____	_____
2. _____	_____-_____	_____	_____	_____
3. _____	_____-_____	_____	_____	_____
4. _____	_____-_____	_____	_____	_____
5. _____	_____-_____	_____	_____	_____
6. _____	_____-_____	_____	_____	_____

(For additional claims, use another reimbursement application) **TOTAL** _____

PART III EMPLOYEE AUTHORIZATION

I authorize the above expenses to be reimbursed from my flexible spending account(s). I certify that the above information is correct and that the expenses claimed were incurred by me, my spouse, or by my eligible dependents after my effective date of coverage in my employer's flexible benefit plan. The submitted expenses are either valid Qualified Medical Expenses or valid Dependent Care Expenses, within statutory limits, as defined in the Plan Document. Any medical care expenses submitted, excluding cosmetic purposes, were not incurred for general health purposes and do not constitute toiletries. I also acknowledge that upon request I must provide additional substantiation concerning my claims (i.e. doctor's letter detailing the specific medical condition being treated). I understand that it is my responsibility to file IRS Form 2441 with my tax return along with any required taxpayer identification number for any reimbursed Dependent Care Expenses. I further certify that none of the above expenses have been or will be submitted for reimbursement or payment from any other source. I have not and will not claim the above expenses on my personal income tax return.

EMPLOYEE SIGNATURE_____ **DATE**_____

BENEFITS DESIGN GROUP, INC.

P.O. BOX 370, Onalaska, WI 54650 1-800-342-8235 or (608) 781-2159 Fax (608) 781-4576

HOW TO FILE A CLAIM

To receive reimbursement for eligible expenses, mail **OR** fax (not both) a completed claim form along with IRS-required documentation of the expense which must include all of the following:

— date of service/purchase
— type of service/supply provided
— name of provider of service
— amount charged for each service/supply or the amount not reimbursed by insurance

CANCELLED CHECKS DO NOT QUALIFY AS THIRD-PARTY DOCUMENTATION AND ARE NOT ACCEPTED BY THE IRS.
Be sure to provide all the information requested on the form. If the form is incomplete or unsigned, it will be returned.

UNREIMBURSED MEDICAL EXPENSES

Medical expenses include payments you make for the diagnosis, treatment, or prevention of disease or for treatment affecting any part or function of the body and the amounts you pay for transportation to get medical care.

The following is a **partial** listing of medical expenses which are allowed and disallowed through your flexible reimbursement. In general, the medical expenses that are allowable deductions on your federal income tax (IRC Section 213(d)) are also reimbursable expenses through your flexible spending account.
It is possible that changes in the IRS rules can affect the Eligible and/or Ineligible Expense categories.

ELIGIBLE MEDICAL EXPENSE

- Lamaze Class
- Prescription Sunglasses, Lasik Eye Surgery, Contact Lens Supplies
- Homeopathic remedies & vitamins used to treat a medical condition*
- Massage Therapy to treat medical condition*
- Smoking Cessation programs or prescriptions
- Prescribed Weight-loss programs or drugs*
- Reconstructive procedures due to medical condition or defect
- Family or Individual Counseling
- Deductibles and Co-Pays
- Over-the-counter medications
- Hearing Aids & Batteries
- Dental fees (crowns, bridges, etc.)
- Orthodontia

** Doctor's letter required*

INELIGIBLE MEDICAL EXPENSE

- General Parenting Classes
- Clip-on or Non-Prescription Sunglasses
- Massage Therapy to reduce stress
- Weight-loss programs for general health and preventative care
- Cosmetic procedures to enhance appearance (i.e. face lift, teeth bleaching)
- Marriage Counseling
- Uniforms
- Maternity Clothes
- Insurance premiums through a spouse's employer
- Hygiene Items (toothpaste, deodorant, etc.)

DEPENDENT CARE FSA

Under the Dependent Care account, you are able to deduct pre-tax dollars for work-related child care or adult day care expenses. The expenses must be incurred during the plan year. Both you and your spouse (if married) must be working, or be a full-time student, to have expenses eligible for payment through the FSA. In the event of divorce, only the custodial parent can claim the dependent care expense. Be conservative and estimate only those expenses you are reasonably certain you will incur during the plan year. Be careful to allow for sick days, vacation time, and other times of the year when you may not be paying the same amount per week for the dependent care.

ELIGIBLE

- Care for dependents (under age 13) of gainfully employed guardians
- Care for dependents who are mentally or physically incapable of self-care
- Baby-sitter, Daycare Provider, Home Care Provider
- Licensed daycare centers caring for more than 6 non-resident people
- Daycare centers caring for less than 6 non-resident people
- Daytime camps or training programs
- Pre-School
- All Latch Key Programs

INELIGIBLE

- Educational programs for dependents
- Care provided by person(s) claimed as a dependent on your, or your spouse's, tax return
- Care provided by child/stepchild under age 19 at end of plan year
- Cost of food, clothing, entertainment unless costs are incidental to care and cannot be separated from the cost
- Care provided by someone not reporting their daycare income
- Overnight camps and transportation
- Field trips