# Instructions for Reimbursement

## General Instructions

- To request reimbursement, a statement, bill or receipt from your service provider(s) showing the services received, must be attached. This statement must clearly identify the service provider, date and type of service provided, and amount of expense. Please note that signed receipt is required for Dependent Care reimbursement as noted below.
- Reimbursement cannot be claimed if the cost can be reimbursed under any other source.
- Services must have been incurred to receive reimbursement. You may not request reimbursement until you have received the service, regardless of when you pay for it.
- Reimbursement can only be made for expenses resulting from services that have been provided within your period of coverage.
- The expenses for which you receive reimbursement cannot be claimed on your income tax return.
- According to IRS regulation, any unused year-end balance in your spending account, may not be carried over to the next plan year. It will be forfeited to your employer.
- If a service is provided during your current period of coverage and will continue to be provided in a subsequent plan year, you will not receive reimbursement for the services you receive in that subsequent plan year unless you reenroll in the account(s) and submit a reimbursement request form for that period.
- If dates of service begin in one plan year and end in the next plan year, and you are enrolled for both years, please prorate the expenses and complete a separate form for each plan year.
- Your employer has allowed for a grace period after the end of your plan year which you may submit reimbursement requests for services which occurred during the period of coverage. Refer to your enrollment book for detailed information.
- Copies of cancelled checks are not sufficient documentation of incurred expenses.
- Please send legible photocopies of your original statements, bills or receipts.
- Be sure to sign and date this form, after reading it carefully.
- You may access your account information or request Reimbursement Request forms, 24 hours each day, by calling our toll-free Interactive Benefits Information Line at 1-800-865-3262.

## Additional Medical Expense Flexible Spending Account Instructions

- Make sure you complete Section B in its entirety.
- Medical expense reimbursement requests must be submitted with copies of a statement, bill or receipt from your service provider(s) showing the date that the service has been received.
- For reimbursement of prescription costs, you must supply prescription name and number.
- Expenses for "cosmetic surgery" are **ineligible** for reimbursement through a medical expense account. The services must promote proper function of the body or are designed to treat, prevent, cure or mitigate a specific medical condition as defined by IRS regulations. A letter from your health care provider indicating the services are medically necessary must be submitted with the request for reimbursement of services which are generally considered cosmetic in nature.
- Orthodontic procedures for primarily cosmetic reasons are not eligible for reimbursement.
- If you are not covered by a HMO, you must also submit copies of the "Explanation of Benefits statement" (EOB) issued to you by your insurer, or a letter specifically explaining the expense is **not** covered by your insurance.
- An "Explanation of Benefits statement" is not required if the entire expense for medical services is being applied to your deductible.

## Additional Dependent Care Flexible Spending Account Instructions

- Make sure you complete Section C in its entirety.
- The dependent care expenses must be provided to allow you and your spouse to work or to look for work. Your spouse is considered working if he or she is a full time student or incapable of self care.
- The total dependent care expenses this year can not exceed the lesser of you or your spouse's earned income for the year as adjusted for disability or periods of schooling or searching for employment.
- According to IRS regulations, dependent care reimbursement requests cannot be processed without receipts from the provider showing the name, address, and tax I.D. Number (or Social Security number) of the provider. A signature is required if your provider is an individual. Beginning and ending dates of service are required on the dependent care receipt. In lieu of a separate receipt your day care provider may sign this form.
- Fringe Benefits Management Company is unable to authorize payment until after the last date of service for which you are requesting reimbursement.
- A qualified dependent is your dependent under age 13, your dependent who is physically or mentally incapable of self care or your spouse who is physically or mentally not able to care for himself or herself. According to the IRS, physical or mental incapacity is not being able to dress, clean or feed oneself.
- Payments for dependent care cannot be made to someone you or your spouse claim as a dependent and, if the person you make payments to is your child, he or she must have been age 19 or older by the end of the year.
- Tuition is not a reimbursable expense.
- Overnight camp expenses do not qualify for dependent day care reimbursement.
- Educational expenses incurred for a child in grades 1 and up do not qualify as a reimbursable expense; however, before and after school care expenses can be claimed.
- Expenses such as registration fees, activity fees, books, supplies and meals are not reimbursable.

Mail only the *white* copy:

**Fringe Benefits Management Company**
**Post Office Box 1800**
**Tallahassee, Florida 32302-1800**
**CUSTOMER SERVICE: (800) 342-8017 • FAX: (850) 425-4608**
**Interactive Benefits Information Line: (800) 865-3262**

**If your request is faxed to FBMC, retain your copy for your records. (Do not mail it to FBMC)**

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 _____

Do you have coverage for medical expenses? Yes ☐ No ☐
Is your medical coverage provided through an HMO plan? Yes ☐ No ☐
Is any portion of the service covered by your medical coverage? Yes ☐ No ☐

Was the amount applied to your deductible: Yes ☐ No ☐
Was the amount you paid a co-payment? Yes ☐ No ☐

**SUMMARY OF EXPENSES**

| Name of person receiving services | Relationship to employee | Provider of services* | Deductible or Co-Pay | Dates of service ** From Mo/Day/Yr | To Mo/Day/Yr | Amount to be reimbursed |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | **TOTAL** | |

* "Provider" means hospital, doctor, dentist, drugstore, medical supply store, etc.
** Use date on which service was provided, not the date you paid for it.

| FOR OFFICE USE ONLY | DATE | AUTHORIZATION # | INITIAL |
|---|---|---|---|

**C. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

Is the facility Tax Exempt?*** Yes ☐ No ☐ Tax ID# or social security # of Day Care provider

**SUMMARY OF EXPENSES**

| Name of person receiving services | Age and grade | Relationship to employee | Provider of services* and address | Dates of service ** From Mo/Day/Yr | To Mo/Day/Yr | Amount to be reimbursed |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | **TOTAL** | |

* "Provider" means day care center, person who gave care, etc.
** Use date on which service was provided, not the date you paid for it.
*** If the facility is Tax Exempt, the I.D. Number is not required.

**SIGNATURE OF DAY CARE PROVIDER** _____

The above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me or my eligible dependents on the date(s) indicated.
I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

**SIGNATURE:** _____ **DATE:** _____

| FOR OFFICE USE ONLY | DATE | AUTHORIZATION # | INITIAL |
|---|---|---|---|