

## FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM INSTRUCTIONS

### Claim Submission:

Fax Submission: To expedite your claim, fax the completed and signed reimbursement claim form, along with all documentation, to (616) 464-4458. **Note: please fax one claim form and its documentation per transmission.**

Mail Submission: Please mail the completed and signed reimbursement claim form, along with all documentation, to ASR Health Benefits, P.O. Box 6392, Grand Rapids, MI 49516-6392.

**Note: please keep a copy of the reimbursement form for your records.**

### EMPLOYEE INSTRUCTIONS

**Please read these instructions before completing the reverse side of this form.**

1. Complete **all** required areas of Part I: Employee Information. Where applicable, complete Part II: Health Care Reimbursement Request and Part III: Dependent Care Affidavit and Reimbursement Request.
2. File all health care expenses first under your employer's health care plan or any other health plan you may have before you request reimbursement from your Flexible Spending Account.
3. Use this form to request reimbursement only for the following expenses:

#### Health Care Expenses

Allowable expenses covered, but not fully reimbursed, by any benefit plans. Attach a copy of the plan's Explanation of Benefits (EOB) statement as documentation.

Allowable expenses not covered by any benefit plans. Attach bills or receipts that indicate the name and address of the provider of service. Please note on the form if the expense is not covered by a health or dental plan.

**Supporting Documentation – Health Care Expenses:** In addition to completing the reimbursement form, you must attach the documentation described under either item A. or B. below:

- A. **Explanation of Benefits statement**—You receive this statement each time you or your health care provider submits medical, dental, or vision claims for payment to your health, dental, or vision care plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your (or your dependent's) medical, dental, or vision plans, you must attach the EOB.
- B. **Receipts**—For expenses not covered at all by your (or your dependent's) medical, dental, or vision plans, reimbursement requests **will not** be processed without acceptable evidence of your expenses (no cancelled checks). Acceptable evidence includes receipts that contain the following information:
  1. Type of service or product provided
  2. Date expense was incurred
  3. Name of employee or dependent for whom the service/product was provided
  4. Person or organization providing the service/product
  5. Amount of expense

#### Dependent Care Expenses

In general, the following rules apply to dependent care expenses:

- Dependent care expenses qualify if they are for the care of a child or other dependent who is physically or mentally incapable of caring for his or herself. These expenses must be incurred so that you and your spouse—if you are married—can work, or your spouse can attend school full-time.
- Children must be under age 13.
- Services provided by a childcare or elder care center must comply with all state and local laws to be eligible reimbursement expenses.
- The annual amount of dependent care claims cannot exceed the following:
  - ✓ Your annual deposit amount up to \$5,000 (\$2,500 if you and your spouse are filing separate returns).
  - ✓ Your annual salary or your spouse's annual salary, if less than \$5,000.

**Supporting Documentation – Dependent Care Expenses:** In addition to completing the reimbursement form, you must include the documentation described in both items A. and B. below:

A. For allowable dependent (day) care expenses, attach a copy of the bill or signed receipt or ask the provider to complete Part III: Dependent Care Affidavit and Reimbursement Request.

B. Please supply, or ask the providers to supply, the tax ID number for all providers of dependent care. Requests **will not** be processed without this number.

4. Read Part IV: Employee Certification for Reimbursement, then sign and date the form where indicated