ASR health benefits

P.O. Box 6392 • Grand Rapids, MI 49516-6392 • Phone: (800) 968-2449 • Fax: (616) 464-4458
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FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM

Please read the instructions printed on the reverse side of this form before completing the following information.

Company Name: Ferris State University **Group Number:** 668

Part I: Employee Information (Please print)

Employee Name (Last/First/MI)		Date of Birth
Employee Address		Daytime Telephone Number
City	State	ZIP Code
☐ **Change of Address Submission** – Please check box if above address is a change from what ASR has on file.		

Part II: Health Care Reimbursement Request

All Dates are: mm/dd/yyyy Y/N Y/N

Type of Service (combine same type of expenses)	Total Paid	Dates of Service (when combining expenses, use earliest and latest dates of service)		Covered by insurance	Explanation of Benefits Included	Total Requested Amount
		Beginning Date	Ending Date			
Medical						
Vision						
Prescriptions*						
Dental/Orthodontics						
Other						
					Total Amount for All Services	$ 0.00

Part III: Dependent Care Affidavit and Reimbursement Request

	Dependent's Full Name	Date of Birth	Dates of Service		Total Requested Amount
			Beginning Date	Ending Date	
1					
2					
				Total Amount for All Services	$ 0.00

Provider Name: _____ **Tax ID Number:** _____

I provided Adult/Child Care Services to the above individual(s) in accordance with the amounts and dates that are requested:

Provider Signature: _____ **Date:** _____

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM.

Part IV: Employee Certification for Reimbursement

I hereby certify all of the following:

- The above information is correct.
- If I am an eligible individual who contributes to a health savings account (HSA), or my employer contributes to an HSA on my behalf, I understand that only my uninsured dental and vision expenses, preventive care expenses, and other expenses incurred after the minimum annual deductible under the high-deductible health plan is satisfied may be reimbursed from my medical FSA.
- *Any prescription or non-prescription drugs that I am submitting claims for are used for medical care as defined by the Plan. I will submit an over-the-counter medication for reimbursement *only if a health-care provider prescribes it* (with the exception of insulin)
- I have not received reimbursement previously, nor will I seek reimbursement, for these expenses from my flexible spending account(s) or any other plan.
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000.
- I have obtained, or have exercised due diligence to obtain, the taxpayer ID number or social security number of the person or business providing the dependent care. I understand that this number is required of me in order for the Plan to reimburse my dependent care expenses on a pre-tax basis. I also understand that I am required to include this information with my tax return on IRS Form 2441.

I understand all of the following:

- Reimbursement is not a guarantee that this payment is tax free.
- Reimbursement of dependent care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return.
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal income tax return.
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my flexible spending account(s). I hereby authorize ASR or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (including other insurers) in order to consider the claim for reimbursement under my flexible spending account(s).

Employee Signature: _____ **Date:** _____

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FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM INSTRUCTIONS

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

1. 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.
2. Complete all required areas of Part I: Employee Information.
3. Complete Part II: Health Care Reimbursement Request to request reimbursement of health care expenses.
   a. Allowable expenses covered, but not fully reimbursed, by any benefit plans.
   b. Allowable expenses not covered by any benefit plans.
4. Attach supporting documentation for your health care reimbursement request.
   a. EOB. 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:
      i. Type of service or product provided
      ii. Date expense was incurred
      iii. Name of employee or dependent for whom the service/product was provided
      iv. Person or organization providing the service/product
      v. Amount of expense
5. Complete Part III: Dependent Care Affidavit and Reimbursement Request to request reimbursement of dependent care expenses.
   a. Expenses for care of a child under age 13 or other dependent who is physically or mentally incapable of caring for his or herself so that you and your spouse (if married) can work, or your spouse can attend school full-time.
   b. Services provided by a childcare or elder care center that comply with all state and local laws.
6. Attach supporting documentation for your dependent care reimbursement request.
   a. Bill or Signed Receipt. Provide a copy of the bill or signed receipt, or ask the provider to sign Part III: Dependent Care Affidavit and Reimbursement Request.
   b. Tax ID Number. 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.
7. Read Part IV: Employee Certification for Reimbursement, and then sign and date the form where indicated.
8. Submit the reimbursement form in one of the following ways:
   a. Fax the completed and signed reimbursement claim form, along with all documentation, to (616) 464-4458. **Note: please fax one claim form (with its documentation) per transmission.**
   b. 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.
   c. E-mail the completed and signed reimbursement claim form, along with all documentation, to submitflexclaim@asrhealthbenefits.com.

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