Print Form

P.O. Box 6392 • Grand Rapids, MI 49516-6392 • Phone: (800) 968-2449 • Fax: (616) 464-4458 • www.asrhealthbenefits.com

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM

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

Company Name: _____ Group Number:_____

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

Type of Service Combine all same type of service expenses.	Total Paid	Dates of Service When combining Type of Service expenses, use earliest and latest dates of service in group.		Covered by insurance (Y/N)	Explanation of Benefits (E.O.B.) Included (Y/N)	Total Requested Amount
		Beginning Date	Ending Date			
Medical						
Vision						
Prescriptions*						
Dental/Orthodontics						
Other						

Total Amount for All Services

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

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 Reimbursement Program.
- *Any non-prescription drugs for which I am submitting claims are used for medical care as defined by the Plan.
- I have not received reimbursement previously 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

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