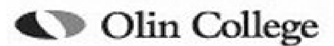
Request for Reimbursement

BenefitsWorkshop
P.O. Box 56828
Jacksonville, FL 32241

info@BenefitsWorkshop.com
Phone - (888) 537-3539
Fax - (904) 880-2830



Employee Name: ______________________

Employee Social Security Number: ______________________

Employee Home Address: ______________________

City, State, ZIP: ______________________

Is this a new address (circle one): Yes No Home Phone Number: ______________________

Please print. Submit additional forms if necessary. Include appropriate proof of expense such as a receipt or insurance company statement.
See the back of this form for more information.

Health Care Flexible Spending Account (FSA)

Patient Name	Relationship to Employee	Provider Name	Service Received	Date of service	Amount

Dependent Care (Day Care) Flexible Spending Account (FSA)

Provider Name	Provider Tax ID (or SSN)	Provider Address (include City, State and Zip Code)
A		
Have Provider sign to the right if receipt(s) not included >		
B		
Have Provider sign to the right if receipt(s) not included >		

Name of Dependent	Relationship to Employee	Age	Provider (A or B)	Date of Service	Amount
			A B		
			A B		
			A B		
			A B		

Authorization

I hereby certify that the information provided is correct and authorize release of funds from the reimbursement accounts indicated above. I understand that payment of these funds is made in accordance with the Plan provisions as governed by the Internal Revenue Code and that payment of these funds by the administrator is not a guarantee that the submitted expenses are eligible for reimbursement. I further certify that these expenses have not been reimbursed under this plan and are not reimbursable under any other plan that covers me, my spouse (if any) or my dependents (if any).

______________________ Signature

______________________ Date

Instructions for Completing This Form

1. Complete the personal information at the top of the form.
2. Indicate if your address has changed in the past 30 days.

If you are filing a Request for Reimbursement Health Care Expenses, from the FSA:

1. Enter the Patient's Name
2. Enter the Relationship to the Employee (self, spouse, child, step-child, etc.)
3. Enter the Provider's Name (Dr. Smith, Smith Chiropractic, Smith Hospital, Smith Drugs)
4. Enter the Type of Service Received (Check-up, immunization, tonsilectomy, etc.) Please be specific.
5. Enter the Date of Service. Enter a date ragne if the service took multiple days.
6. Enter the amount of the Reimbursement Request. DO NOT include amounts reimbursed by other plans.
7. Sign and date the form.
8. Attach proof of expense such as a detailed receipt, bill or Explanation of Benefits from an insurance plan showing at a minimum, the type of service(s), the date service(s) were rendered, the amount you paid, the provider's name.

If you are filing a request for reimbursement from the Dependent Care (Day Care) FSA:

1. Enter the Provider Name on Line A.
2. Enter the Provider's Federal Tax ID Number or Social Security Number.
3. Enter the Provider's Address including City, State and Zip Code
4. If you do not have a receipt, have the provider sign the form, certifying that the expense was actually incurred.
5. If there is a second Provider, complete the same information in Section B.
6. Enter the Name of the Dependent.
7. Enter the Relationship to the Employee (self, spouse, child, step-child, etc.)
8. Enter the Age of the Dependent.
9. Select the Provider Information for this expense.
10. Enter the Date of Service(s)
11. Enter the Amount of the Request.
12. Sign and date the form.
13. Attach proof of expense such as a detailed receipt, unless you had the provider sign the front of this form.

Important Notes:

You must provide proof of expense along with this Reimbursement Request Form. Proof of Expense includes either a detailed receipt, a detailed bill, or a statement from an insurance plan (Explanation of Benefits) showing the portion of the expense you had to pay. If you use a Day Care provider that cannot give you a receipt, such as an individual, you may have the individual sign the receipt to verify the expense. Mail or fax this request form and proof of expense to the address or fax number on the other side of this form. Health Care FSA expenses must be incurred while you are a participant in the plan and by March 15 following the end of the plan year. Dependent Care FSA claims must be incurred during the plan year. You have until April 30 following the plan year to file claims. Unused funds are forfeited.

Eligible Health Care Expenses include (but are not limited to):

Acupuncture	**Deductibles**	Hospital services	Nursing Services	Sterilization
Ambulance	Dentist	Lab Fees	Optometrist	Smoking Cessation
Birth Control Pills	Drugs	Laser Eye Surgery	Orthodontist	Surgery
Chiropractor	Drug Addiction	Learning Disability	Osteopath	Transplants
Coinsurance	Eyeglasses	Long Term Care	Oxygen Therapy	Vasectomy
Contact Lenses	Fertility Treatment	Medical Services	Psychiatry	Wheelchair
Copayments	Hearing Aids	Medicines	Psychology	X-rays

Ineligible Health Care expenses include (but are not limited to):

Expenses that are not necessary for the diagnosis, cure, treatment, mitigation or prevention of a specific medical condition.

See BenefitsWorkshop.com/olin for more information or contact Human Resources.