Debit Card Transaction

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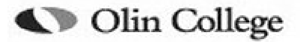

Employee Name: ______________________________

Employee Social Security Number: ______________________________

Employee Home Address: ______________________________

City, State, ZIP: ______________________________

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

Please print. USE THIS FORM TO DOCUMENT DEBIT CARD TRANSACTIONS ONLY! 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	Transaction Date	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 to document a Health Expense Debit Card Transaction:

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 range if the service took multiple days.
6. Enter the amount of the Debit Card Transaction. 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 to document a Dependent Care (day care) Expense Debit Card Transaction:

1. Enter the Provider Name on Line A.
2. Enter the Provider's 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 (Provider A or Provider B).
10. Enter the Date of Service(s)
11. Enter the Amount of the Debit Card Transaction.
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 Debit Card Transaction 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 form and proof of expense to the address or fax number on the other side of this form. You have 20 days after using the Debit Card to document the expenses.

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.