

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form with the documentation attached to your Benefits Coordinator or directly to Administrative Solutions, Inc.

**** MEDICAL EXPENSE and OVER THE COUNTER MEDICATION CLAIMS ****

Please list and attach the Explanation of Benefits (EOB) from your insurance company or invoices (if the service is not covered by insurance and, therefore, no EOB is available). If you are providing documentation other than the EOB from your insurance company, these documents must be from the third parties who provided the medical services and must show ***the names of the providers, the dates that services were provided, the amounts charged for the services, and a brief description of the services.***

In general, the types of medical services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would allow for the medical and dental expense deduction under Internal Revenue Code Section 213. Some examples include: Medical and dental expenses which are covered but not paid by insurance (deductibles, co-payments), and items allowed by IRC Section 213 that are not covered by your insurance plan (ie., vision and hearing expenses, dental care, routine examinations, prescription drugs. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached. At any time during the plan year, you may request reimbursement for expenses that may exceed the amount that you have deposited into your Flexible Spending Medical Account. However, your reimbursement cannot exceed the amount that you have committed to contribute for the Plan Year, minus any reimbursements you have already received for the Plan Year. Special rules apply if you terminate employment or otherwise end your participation in the Plan. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of the maximum reimbursement amount.

**** DEPENDENT CARE EXPENSE CLAIM ****

Please list and attach invoices issued by the third parties who provided the dependent care. This documentation must show ***the name and tax identification number of the provider, the dates that services were provided, and the amounts charged for the services.***

In general, the types of expenses for dependent care services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Section 21(b)(2). Expenses must be for dependents under the age of 13 or incapable of caring for themselves. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you make contributions into your dependent care reimbursement account. And, you cannot ask the plan to reimburse you in advance. For example, if you start contributions with the pay period that begins on February 1, on February 2 you can submit a claim for child care given on February 1, but not for care given on January 31 or for care to be given in March.

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached. If your expenses qualify for reimbursement from the Plan, you will be reimbursed for the total of your expenses, but not more than your account balance in the Plan. Your account balance is the total of the contributions you've made into your Dependent Care Flexible Spending Account minus the reimbursements you've received for the Plan Year.

**** STATEMENT BY PARTICIPANT AND SIGNATURE ****

Besides providing the information that is needed to prove that your claim is for qualified for reimbursement, you must sign this form on the reverse side. You are thereby swearing that you have not and will not submit the expenses claimed for reimbursement from another Flexible Benefit Plan or use these same expenses in order to receive a tax deduction or credit on your annual income taxes.

** Invoices Must be Attached ** Total Amount Requested ** Participant's Signature Required**
