FLEXIBLE SPENDING ACCOUNT (FSA) REQUEST FOR REIMBURSEMENT FORM

Employer ____

Employee Name ______________________________ Soc.Sec.No. ____________
Last First M.I.

Home Address ____
Number/Street City State Zip

Daytime Telephone Number ________________ E-mail Address ________________

☐ Please check only if this is a new address

Direct Deposit Authorization – Please complete this section to have your FSA reimbursements direct deposited into your checking or savings account. This is a faster, more secure method of reimbursement. If you are already set up for direct deposit, there is no need to complete again. You may attach a voided check if you are unsure of your routing and/or account number.	
Name of Banking Institution:	Routing Number:
Account Type: ☐ Checking ☐ Savings	Account Number:

HEALTH FSA

(See documentation requirements and guidelines on reverse side of claim form)

Date of Service	Patient's Name & Relationship	Description of Service	Provider of Service	Amount of Reimbursement

Total Expenses $______________

DEPENDENT CARE FSA

Please attach a receipt or statement from your dependent care provider showing the "from/through" dates of service, or have your provider sign the receipt on the back of this form. Please note: services must actually be rendered prior to requesting reimbursement (see reverse).

Date of Service From mo/day/year to mo/day/year	For the Benefit of (Name and Relationship)	Provider of Service	Amount of Reimbursement
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

Total Expenses $______________

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I will not seek reimbursement from any other health plan coverage or any other source. I also certify that the expenses were incurred by me and/or my IRS dependents, and will not be applied toward any federal or state income tax deduction or credit.

____
Employee Signature *Date*

Note: To access your balance and claims history, you may register for online access to your account information at www.myrsc.com. Contact Arcadia for your "employer code" to register. **You must sign this form to be reimbursed. Mail or fax to:**

Arcadia Benefits Group, Inc. • 445 W. Michigan Ave., Suite 102 • Kalamazoo, MI 49007
Phone: 269-744-3431 • Toll Free: 866-329-4333 • Fax: 269-381-5844 • E-mail: info@arcadiabenefits.com Rev. 10/10

INSTRUCTIONS AND DOCUMENTATION REQUIREMENTS FOR FSA REIMBURSEMENT

Please read these instructions before completing the front of this form. Failure to provide the information required by the IRS could delay your reimbursement. All copies must be legible.

Documentation requirements for Health Care expense reimbursement:

1. For **medical or dental** expenses that will be processed under your underlying insurance plans, please submit the expenses to your insurance carrier first. Then submit a copy of the Explanation of Benefits (EOB) to Arcadia with this form. Proof of payment of the expense is **not** required.
2. If you do not have insurance coverage for **dental** expenses, submit an itemized statement from your dentist showing the patient name, name and address of the provider, date of service, description of service and amount of charge. Some dental expenses that are not eligible are teeth bleaching and veneers placed for cosmetic reasons.
3. For **orthodontia** expenses, please submit a copy of the Truth in Lending Statement (contract/treatment plan) with your initial submission itemizing the treatment period, down payment and amount of monthly payments, and the amount covered by insurance, if any. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment. *Note:* the plan cannot reimburse for future service or for the portion of treatment occurring in another plan year unless a lump sump is paid for the full cost of the treatment at the beginning of treatment.
4. For **vision** expenses, if you do not have insurance coverage for vision, submit an itemized receipt from your vision provider showing the date of service, description of charge (exam, Rx glasses, contacts, etc.) and amount of charge. Some vision expenses that are not eligible are warranty charges, protection plans and sun-clips for prescription glasses. To be reimbursed for contact lens solutions and cleaners, you may submit a cash register receipt as long as the receipt shows a description of the item. If not, you must submit a portion of the package with the price along with the cash register receipt to verify the item purchased.
5. For **Rx co-payments,** submit a copy of the prescription co-payment receipt showing the patient name, name of the drug, date the Rx was filled, and co-payment amount. Some Rx drugs are not eligible for reimbursement, including drugs taken for cosmetic reasons (i.e., Rogaine or Retin-A) or drugs taken for weight loss (unless there is a specific medical necessity).
6. For **OTC items**, **please note that effective 1/1/11, OTC medicines and drugs are not eligible without a doctor's written prescription.** OTC supplies such as contact lens solutions remain eligible without a doctor's prescription. Submit a copy of your cash register receipt detailing the name of the OTC item, date purchased and amount. If the cash register receipt does not specify the name of the OTC item, submit a tear-off portion of the box or package that includes the name and price, and submit along with the cash register receipt. OTC drugs taken for general good health are also not eligible (e.g., vitamins and supplements).
7. For **other expenses**, always submit itemized statements. A letter of medical necessity may need to accompany some charges (i.e., massage therapy, tutoring for a learning disability, and cosmetic procedures).

The total annual election for eligible health care expenses (less any previous reimbursements paid) is available from the beginning of the plan year. For a more complete list of eligible expenses, you may obtain a copy of IRS Publication 502; however, please note that premiums are not eligible for reimbursement. An eligible health care expense is any item for which you could have claimed a medical expense deduction on Schedule A of your federal income tax return (with the exception of insurance premiums). Expenses must be incurred by you or your dependents while participating in the plan.

Documentation requirements for Dependent Care expense reimbursement:

1. Submit a receipt or statement from your day care provider showing the "from/through" dates of service, description of the charge (i.e., child care or preschool) and the amount of the charge. Proof of payment is not required. You may have your provider sign the receipt at the bottom of this form each time you request reimbursement.
2. Some expenses associated with dependent care are not eligible, including overnight camp, food and transportation costs. If you are submitting charges for a day camp, please make sure the documentation shows that it is a *day* camp.
3. Your claim cannot be processed until after the services have actually been rendered. For example, if you pay your child care weekly on a Monday for that week, you should submit your claim on Friday after the services have been rendered. If you pay your child care expenses on a monthly basis, you will need to wait until the last day of the month to submit for reimbursement.

IMPORTANT: You must provide the IRS with the name, address and Tax I.D. (or Soc. Sec. No.) of the dependent care provider on your federal income tax return by completing Form 2441. If you are unable to provide this information, the exclusion for the dependent care spending account may be denied by the IRS.

Receipt for Child Care Services

For the Time Period: ___________ through ___________

For the Amount of $___________

Paid by: ____

Received by: ____________________________________

Date: ____________________________