



FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Request for Reimbursement from Employee Flexible Spending

Complete applicable sections, sign and attach appropriate claim substantiation information and submit to Benefits Connection, LLC.

PARTICIPANT INFORMATION AND SIGNATURE

By submitting this claim form I (participant named below) request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and Conditions stated below; I certify and warrant that these are eligible medical and/or dependent day care expenses that I or my dependents have incurred.

EMPLOYER Clarksville Montgomery Emp. Ins. Trust

EMPLOYEE NAME: _____ SOCIAL SECURITY: _____

HOME ADDRESS: _____

How may we contact you during the day? E-mail: _____ Phone: _____

PARTICIPANT SIGNATURE: _____

CHILDCARE (DAY CARE) EXPENSE CLAIMS

Please attach a receipt or itemized bill listing or have the provider certify below.

Do not write in this section:

NAME OF DEPENDENTS	FROM	TO	NAME AND ADDRESS OF PROVIDER	AMOUNT	

Provider Certification/Verification: I certify that the Dependent Day Care expenses listed above were incurred by the Employee named above:

Business/Provider Original Signature

Address

Date

Note: The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. No payment may be made under the plan if the service provider is your dependent for federal tax purposes, or is your child or stepchild and is under the age of 19.

UNREIMBURSED MEDICAL

List each receipt separately. Use additional forms if necessary.

DATE INCURRED	PROVIDER NAME	DESCRIPTION	NAME OF CLAIMANT	AMOUNT	Do not write in this section:

Terms and Conditions

I (above named Participant) understand and agree that:

- these expenses are not reimbursable from any other health plan, insurance, or other source, and will not be used to claim any federal income tax deduction or credit;
- the Dependent Day Care expenses listed above qualify for the federal child care credit, and I will not be eligible to claim the tax credit for any Dependent Day Care expenses submitted;
- I will include the Taxpayer Identification/Social Security Number(s) of any Dependent Day Care service provider(s) listed above on my annual tax return(s) using Form 2441;
- I am responsible for any inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this form (e.g., fax, e-mail, or any other media);
- I authorize the Plan and its service provider, their respective agents, employees, sub-contractors and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan Administration purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation;
- I give up any claim related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above; and
- this authorization does not in any way limit any right that the Plan, their respective agents, employees, sub-contractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

Benefits Connection, LLC

P.O. Box 681569 - Franklin, TN 37068-1569

Toll Free (877) 384-7539

Claims Fax (877) 239-6635

Helpful Hints for Completing & Filing Your FSA Claim Form

- Complete, Sign, and Date the front side of this form. Failure to Complete all areas can result in a processing delay of your claim reimbursement.

Please Note: All the required fields must be completed on this form; do not indicate "See attached" in any field.

Attach a legible receipt (or receipts) from the service provider showing the following information:

- A description of the service
- The charge(s) for each service that was rendered
- The date(s) of service
- The name of the individual receiving the service

Health Care Spending Account Eligible Expenses- Refer to your Plan Document/SPD for details and limitations.

Services offered by an M.D. or Licensed Medical Practitioner when medically necessary, which may include:

- | | |
|----------------------------------|----------------|
| - Anesthesiologist | - Optometrist |
| - Chiropractor | - Pediatrician |
| - Christian Science Practitioner | - Podiatrist |
| - Dermatologist | - Psychiatrist |
| - Obstetrician | - Psychologist |
| - Ophthalmologist | - Surgeon |

Dental, vision, & hearing expenses

- Annual dental exams, fillings, braces, extractions, and dentures
- Orthodontics
- Braille books and magazines
- LASIK, Laser, RK surgery, prescription eyeglasses, and contact lenses
- Cost of a guide dog for the visual and hearing impaired
- Hearing aids and batteries
- Household visual alert & expenses for special phone equipment for a deaf individual

Medical & Hospital Services that have not been covered by your employer's plan or another plan:

- Diagnostic services by an M.D.
- X-rays and radiological services for diagnosis or treatment
- Nursing services provided by an RN or other attendant
- Services offered by a physical, speech, or occupational therapist
- Surgical services by or under the direction of an M.D.
- Expenses for receiving an organ transplant
- Ambulance
- Laboratory fees
- Prescription Drugs: including insulin, & birth control pills
- Over-the-counter drugs & medications**
- Vitamins and dietary supplements***
- Vaccinations and immunizations

*** If used for the diagnosis, cure, mitigation, treatment, or prevention of disease and in some cases for the purposes of affecting any structure or function of the body. Some OTC items may require a letter of medical necessity from their physician.***

****If specifically directed and prescribed by a physician.****

Other health related expenses

- Smoking cessation programs and related drugs
- Removal of lead-based paint in the home
- Treatment of alcoholism or drug dependency

Expenses ineligible for reimbursement

- Prepayment for services
- Health club membership
- Cosmetic procedures/surgeries
- COBRA premiums
- Funeral expenses
- Founders fee
- Medicare Part B premiums
- Marriage counseling
- Any illegal treatment
- Household help
- Lifetime care
- Teethbleaching or whitening
- Toiletries and sundry items (i.e.toothpaste, shaving cream, ect.)
- Weight reduction programs for general well being

Dependent Care Eligible Expenses- Refer to your Plan Document/SPD for details or limitations.

- | | |
|--|--------------------------------|
| - Care for a dependent under the age of thirteen or a qualified individual incapable of self care | - Qualified child care centers |
| - Licensed nursery schools | - Adult day care facilities |
| - Baby-sitters inside or outside the home while you (and your spouse) are at work. (As long as the individual is not your child and under the age of 19, or anyone you and your spouse can claim as a dependent for federal income tax purposes) | - After school programs |

Expenses not covered:

- | | |
|---|---|
| - Overnight camp expenses | - Weekend or evening baby-sitting that is not necessary for you (or your spouse) to work |
| - Tuition fees for private or boarding homes | - 24 hour nursing home care |
| - Expenses for which you claim a tax credit on your federal income tax return | - Care provided for your child by a sibling under the age of 19 or someone you can claim as a dependent on your income tax return |
| - Kindergarten expenses | |

The above are some examples for eligible/ineligible expenses that can be reimbursed through Flexible Spending Accounts. All claims are reviewed when they are received and the determination of eligibility or reimbursement is made based upon the information received from the plan participant. This list is not intended to be a guarantee of reimbursement or eligibility.

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