Administered by:
Employee Benefit Solutions of NY

Flexible Spending Account Claim Form

A. INSTRUCTIONS

- COMPLETE SECTIONS B, C. D, E AND F.
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER
- ATTACH INSURANCE CARRIER'S EXPLANATION OF BENEFITS IF APPLICABLE
- IF YOU ARE SUBMITTING ITEMIZED BILL ONLY, INDICATE WHY ITEM WAS NOT COVERED BY INSURANCE
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS, AND BALANCE DUE BILLS ARE **NOT ACCEPTABLE** PROOF OF EXPENSES
- FOR ADDITIONAL CLAIM FORMS OR IF YOU HAVE ANY QUESTIONS, PLEASE CALL 914-762-6500
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO:

Employee Benefit Solutions of NY
P.O. Box 421
Ossining, NY 10562

- YOU CAN FAX CLAIM FORM AND ALL DOCUMENTATION TO: **914-762-6508**

B. EMPLOYEE INFORMATION

Company Name	Account Number	Location

Last Name	First Name

Address	City	State	Zip Code

C. HEALTH CARE EXPENSES

Patient	Provider	Dates of Service	Total Charge	Paid by Other Sources	Amount to be Reimbursed

D. DEPENDENT CARE EXPENSES

Dependent	Provider	Tax I.D. #	Dates of Service	Type of Expense	Charge

E. TRANSPORTATION EXPENSES

Description of expense	Dates of Service	Charge

F. CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all the following conditions:

- They were incurred for services or supplies furnished on or after the effective date of my employee spending account.
- They were incurred for services or supplies by me or my eligible dependents under the plan.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted and will not deduct on my individual income tax return any of the expenses reimbursed through my Flexible Spending Account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE (*Required)*	DATE

FLEXIBLE SPENDING ACCOUNT
CLAIM FILING INSTRUCTIONS

Who Can File a Claim Form

- Only employees participating in the FSA Plan can file a reimbursement claim form.
- Employees can file a claim form during the plan year and for a 90-day period after the plan year as described in the Summary Plan Description.
- Terminated employees can file a claim form for a 90-day period after the date of termination. Please see your Summary Plan Description.

What Expenses Can be Claimed

- Only expenses incurred during the plan year can be claimed for reimbursement. Each year is treated separately and the year of claim is the year the expense was actually incurred by the participant. It is imperative to send separate claim forms for each year.
- Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. Please see your Summary Plan Description.
- Allowable expenses are the same as those allowed for tax purposes. A partial list of covered medical expenses is provided here for your convenience.
- Certain transportation expenses may be covered.

Qualifying Dependent Care Expenses

- Expenses paid to a dependent care center or care provider
- Expenses paid for the care of a dependent under age 13
- Expenses paid for care of other dependents who are physically or mentally incapable of caring for themselves.

Qualifying Unreimbursed Medical Expenses

Only expenses not reimbursed by insurance can be claimed. A few examples are:

Ambulance
Artificial limbs and teeth
Automobile modification (hand controls, special equipment, mechanical lifts)
Braille books
Crutches
Drugs (prescription only or insulin) and medical supplies
Elastic hose, medically necessary
Eyeglasses/contact lenses
Acupuncture
Anesthetist
Blood Donor
Chiropodist
Chiropractor
Christian Science Practitioners
Dentist
Diathermy
Eye Examinations
Gynecologist
Hospital
Laboratory
Lip Reading lessons for the deaf
Midwife
Nurse
Obstetrician
Oculist
Ophthalmologist
Optician
Optometrist
Oral Surgery
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist
Psychiatrist
Psychoanalyst
Psychologist
Psychopathist
Sex therapist
Specialist
Surgeon
Therapy
Hearing devices
Iron lung operating cost
Laetrile when prescribed by a Doctor
Nursing care
Oxygen equipment
Durable medical equipment
Seeing eye dog
Special education
Telephone for deaf
Transportation
Expenses related to illness
Xrays
Wheelchair

Completion of the Claim Form

- Complete **all** information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- You **must** sign and date the claim form.
- Attach a copy of a bill, invoice, or other written statement from a third party which supports each reimbursement request.
- Mail claim form and all supporting documentation to: EBS, P.O. Box 421, Ossining, NY 10562

How to Request Changes in Plan Participation

- Revocation of participation in the Plan can only occur if you have a change in family status. "Change of family status" includes birth, death, marriage, divorce, change of employment by the spouse, or certain other situations as determined by the Plan Administrator.