

**FLEXBenefits**

Request for Reimbursement - Employee Reimbursement Account  
 Mail this completed claim form and appropriate documentation to:

**Employee Benefit Systems, Corporation**  
**P.O. Box 1053**  
**Burlington, IA 52601**

**EBS will mail reimbursement checks on**  
**Wednesday for Claim Forms received**  
**in their office by Monday AM**  
**Fax (319) 758-6271 or**  
**(319) 758-8553**

To Assure Prompt Reimbursement of Your Claim:  
 \* Sign and Date your claim form;  
 \* Provide proper documentation as outlined in boxes 2 and 3 below;  
 \* Check dates of Service; to be reimbursed, expenses must be incurred within this plan year.  
*Detailed Guidelines are included on the reverse side of this form.*

**1. Employee Information - Complete all sections.**

<input type="checkbox"/>  Check box if new address	Name	Social Security Number
	Home Address	Employer
	City State Zip (9 digit if known)	Daytime Phone Number ( ) -

**Employee Certification** - I request reimbursement from the Employee Reimbursement Account(s) for the expenses itemized below. These expenses were incurred within the current plan year, unless I have indicated otherwise in the date fields below. I certify that these expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and as outlined on the reverse side of this form. I also understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. The information on this Request for Reimbursement is true and correct to the best of my knowledge.

Sign here >>>> Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**2. Medical Reimbursement - Attach an itemized receipt, an Explanation of Benefits, or other verification (originals or photocopies) of each expense claimed, indicating the service(s) provided, date(s) of service, and corresponding charges.**

Person Receiving Care	Relationship	Date Expense Incurred	Description of Expense	Care Provider (Name of Doctor, Clinic, Hospital, etc.)	Amount Claimed

**3. Dependent Care Reimbursement - Attach an itemized receipt or other verification (originals or photocopies) of each expense claimed, indicating the service(s) provided, date(s) of service, and corresponding charges. This documentation is not needed if your care provider's certification is obtained below.**

Dependent Receiving Care	Relationship	Age	Date(s) of Care	Care Provider (Name and Social Security No. or Federal T.I.N.)	Amount Claimed

I certify that the dependent care expenses shown above are valid.

Signature of Dependent Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**Plan Administrator Use Only**

Approved for Payment -   Date _____	Returned to Employee - Date: _____ Reason: _____ _____
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# GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

## GENERAL

- \* Reimbursement will be made directly to you.
- \* If you apply for reimbursement of expenses that the IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement of expenses that have already been reimbursed from some other source.
- \* In general, Section 125 of the Internal Revenue Code governs the tax status of Flexible (Cafeteria) Benefit Plans, of which Employee Reimbursement Accounts are a part. Eligibility for pre-tax reimbursement is covered specifically in Code Sections 105 and 106 (Accident/Health Plans) and Section 129 (Dependent Care).

## MEDICAL REIMBURSEMENT

- \* Eligible expenses are qualified medical/dental expenses that are not eligible for reimbursement from any other source. Expenses that can be reimbursed under your health insurance plan should not, for example, be included on this form. Expenses for services which are not medically necessary (i.e. cosmetic) should not be included on this form. You may be reimbursed for expenses for yourself, your spouse and your dependents.
- \* The following expenses are eligible for reimbursement under a Medical Reimbursement Account:

Acupuncture	Medical care in a retirement or nursing home
Ambulance	- meals and lodging are covered only if stay is mainly for medical (non-custodial) care
Birth Control Pills	Optometrist fees
Chiropractic Care	Orthodontic fees
Contact lenses	Physician fees
Deductibles & Copayments	Special Schools - to relieve a handicapped condition
Eyeglasses	Sterilization
Dental fees	Therapy - physical or occupational therapy by a licensed therapist
Guide dog	Vitamins prescribed by a physician
Hearing aids and batteries	Wheelchairs - including rental or purchase
Learning disability-tutoring by a licensed school therapist as recommended by physician	Vaccinations and immunizations
	X-Ray fees

## DEPENDENT CARE REIMBURSEMENT

- \* Expenses to provide care for your dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a disabled parent.
- \* To be eligible, you must be working while your dependents receive care. Also, if you are married, your spouse must be:
  - a wage earner, or
  - a full-time student for at least 5 months during the year, or
  - disabled and unable to provide for his or her own care.
- \* Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:
  - licensed nursery schools and licensed day care centers.
  - individuals - other than your dependents - who provide care for your children in or outside your home, or for your disabled spouse or dependent parent in your home.
- \* You will be required to provide the name, address, and social security number (or other taxpayer I.D. number) of your day care provider on your federal income tax forms at year end.
- \* IRS regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns \$200 per month (one dependent) or \$400 per month (two dependents).
- \* An additional IRS Regulation limits the amount you can contribute to the dependent care account to \$5,000 for a single parent with children, \$5,000 for a married parent filing jointly, and \$2,500 for a married parent filing separately.
- \* Under IRS Regulations, qualified individuals can receive a tax credit for dependent care costs. This credit can be claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by the amount you use from the Dependent Care Reimbursement Account.