

**FLEX PLAN REIMBURSEMENT REQUEST FORM—Page \_\_\_\_ of \_\_\_\_ Total Pages Sent**

*Please type or write clearly in applicable blank spaces below. Failure to complete this section fully may delay the processing of your claim.*

ACCOUNT	<b>PLEASE CHECK</b>	EMPLOYER/GROUP NAME	
Medical Flexible Spending Account (MFSA)		EMPLOYEE LAST NAME	
Dependent Care Assistance Program (DCAP)		EMPLOYEE FIRST NAME	
Health Reimbursement Arrangement (HRA)		SOCIAL SECURITY NUMBER (LAST 4 DIGITS ACCEPTABLE)	
Employer-Funded Medical Expense Reimbursement Plan (MERP)--may include deductible, specific copays, etc.		MAILING ADDRESS	
OTHER (Please specify)		CITY/STATE/ZIP CODE	
PLAN YEAR ACCOUNT from which reimbursement is requested (e.g., 2008, etc.)		EMAIL ADDRESS	

**EXPENSES CLAIMED**

Date of Service/Purchase	Expense Incurred For (name)	Relationship to Employee (self/spouse/dependent)	Expense Description	Your Total Cost (not covered by insurance)
<i>Example:01/15/2008</i>	<i>John Doe</i>	<i>Self</i>	<i>Prescription co-pay</i>	<i>\$25.00</i>
<b>Total Reimbursement Requested (this page only—please use additional forms as needed)</b>				<b>\$</b>

<b>Employee Signature (required)</b>	<b>Date:</b>
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**EMPLOYEE CERTIFICATION**

*To the best of my knowledge and belief my statements in this Reimbursement Request Form are complete and true.*

- **MEDICAL CLAIMS:** I certify that my family member or I have received the services/purchases described above on the dates indicated, and that the expenses qualify as valid medical services/purchases under the Plan. If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent in the Plan. I certify that I have not been reimbursed previously for these expenses under this or any other Reimbursement Plan (i.e., another employer's FSA, HRA, or HSA). I certify that these expenses have not been reimbursed, and are not reimbursable under the Major Medical Plan or any other health plan or Health Savings Account (HSA). If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes (hair growth, weight loss, etc.). I understand that these expenses may not be used to claim any federal income tax deduction or credit. I authorize a deduction to my Medical Reimbursement Account in the amount of the reimbursement requested.
- **DEPENDENT CARE CLAIMS:** I have read, understand and make the certification contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Request form. I understand that these dependent care expenses may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. I authorize a reduction in my Dependent Care Account in the amount of the reimbursement requested.
- **EMAIL CONSENT:** I consent to receive electronic communications at the email address of record, for any and all matters permitted by law regarding this Plan which is sent by, or on behalf of, the Plan or my employer. By signing this consent, I will no longer receive printed copies of communications which are sent to me electronically. I certify that I have access to the above email address and am able to receive electronic messages with attachments at that email address. Should I subsequently provide the Plan Administrator with a different email address to use for these communications, this consent shall apply to that email address also. I understand that I may request a paper copy of any correspondence provided electronically at no charge by contacting the Plan Administrator in writing. The Plan, Employer, nor any agent of the Plan or Employer, shall be held liable for my not having received any communication by virtue of my inability to receive the communication at the email address I have provided. Any electronic communication sent shall be deemed to have been received by me. I may revoke this consent at any time by notifying the Plan Administrator in writing. If I should no longer have access to the email address last provided to the Plan Administrator, I shall immediately provide a new email address or revoke this consent.

Please **MAIL** or **FAX** this **Form** and supporting **RECEIPTS** to:

**Jaeger & Flynn Associates, Attn: Flex Plan Services, 42 South Street, Glens Falls NY 12801 \* Fax: 518.792.0226**

\*\*\* PLEASE RETAIN A COPY OF ALL SUBMITTED INFORMATION FOR YOUR RECORDS—

PLEASE SEE REVERSE OF FORM \*\*\*

For Plans That Include Reimbursement of Qualifying Medical, Prescription, Dental, or Vision Care Expenses

- Your employer's Plan overview and Plan document contain the rules governing what expenses are and are not reimbursable. Please contact the Plan Administrator in writing or by e-mail if you have any questions about item reimbursement eligibility: JFA Flex Plan Services, 42 South Street, Glens Falls, New York 12801 (fax: 518.792.0226). Also, please visit our website at [www.jfaflex.com](http://www.jfaflex.com); click on the link for reimbursable expense examples (access code: jaegerflynn).

For Plans That Include Reimbursement of Pre-Tax Dependent Care Expenses

By signing and submitting this Reimbursement Request Form for qualified dependent care expenses, you are certifying that expenses for which you request reimbursement meet *all* of the following conditions:

1. The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the Plan Year to which the election applies
2. The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of self-care
3. The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of:
  - i. your earned income; or
  - ii. if you are married, your spouse's actual or deemed earned income\*. Your spouse is deemed to have monthly earned income of \$200 (\$400 if you are incurring dependent care expenses for more than one dependent), if your spouse either is a full-time student or is physically or mentally incapable of self-care
4. Each dependent for whom you incur the expense is:
  - a. a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return; or
  - b. your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care
5. You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(A) or 4(B) above
6. The expenses are incurred for the care of a dependent, or for related incidental household services
7. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(A) above (or who is described in 4(B) above and regularly spends at least eight hours per day in your household)
8. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations
9. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred
10. The expenses are not paid for services outside your household at a camp where the dependent stays overnight

**JFA FLEX PLAN SERVICES**  
42 South St  
Glens Falls, New York 12801  
[www.jfaflex.com](http://www.jfaflex.com)