FLEXIBLE SPENDING ACCOUNT
Reimbursement Claim Form

FAX: (877) 587-4434 **E-Mail: nngg_cs@healthsmart.com**
Or, mail to: HealthSmart Benefit Solutions, PO Box 71489, Newnan, GA 30271-1489

Change of address: ☐

Employer: ______________________ **Name:** ______________________

SSN: ______________________ **Phone:** ______________________

Home Address ______________________ **City, State, Zip** ______________________

CERTIFICATION AND AUTHORIZATION

I certify that the Information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependant while I was a participant in the plan. I have not received any reimbursement for these expenses from any other plan and the expenses are not reimbursable under any other source. I further understand that Health care expenses reimbursed through my FSA cannot be used as a deduction on my personal income tax return. Dependent care expenses reimbursed through my FSA will reduce dollar for dollar ($ for $) the eligible tax credit available on my personal income tax return. Even though the dependent care maximum is $5,000 per year, my personal maximum cannot exceed the lesser of my spouse's or my annual earned income if less than $5,000. I may be liable for payment of all related taxes on the amounts paid for any expense improperly claimed under the plan.

Signature of Account Holder X ______________________ **Date** ______________________

A. CLAIMS FOR OUT OF POCKET EXPENSES (Attach Supporting Documentation)

Service Date	Name of Service Provider	Expense Description	Relationship to Account Holder	Out of Pocket Cost
		HEALTH CARE EXPENSE CLAIM TOTAL		

B. DEPENDENT CARE EXPENSES (Attach Supporting Documentation)

Name of dependent	Service date		Provider's Name & SSN or Tax ID #	Out of Pocket Cost
	Start	End		
			DEPENDENT CARE EXPENSE CLAIM TOTAL	

DEPENDENT CARE PROVIDER CERTIFICATION

I certify that I have provided dependent care as described in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this form and noted in (B) above. I have received $__________ as payment for the services I rendered for the above service dates.

______________________ ______________________

Social Security # or Taxpayer ID of Provider **Signature of Dependent Care Provider**

Important Information Regarding Reimbursements

You may be reimbursed for any qualified health care expense defined in your Flexible Spending Account Summary Plan Description which has not been or will not be reimbursed under any other source and has not or will not be deducted on your income tax return.

To request reimbursement of health care expenses, complete this form and attach the following documentation:

- If the eligible expenses are covered by a healthcare plan you must submit them under that plan first. When you receive your Explanation of Benefits (EOB) statement, attach it to this form to claim amounts not paid by your healthcare plan. (An EOB statement explains the benefits paid and charges not paid by your healthcare plan.)
- For all other expenses, attach an itemized receipt which contains the following information:

Sample receipt	Required information
(A) Date of Service __________	(A) Date of Service (date expense was incurred, not paid)
(B) Smith Eye Care 1000 Oak Street Anytown, USA	(B) Service Provider Name/Address
(C) Patient: Ann Jones	(C) Name of Employee/Dependent Who Incurred Expense
(D) Item Description: Exam:$ ______ Frames:$_____ Lenses:$ _____	(D) Itemized Description of Expense
(E) Total Amount $ ____________	(E) Amount of Expense

CERTIFICATE OF QUALIFYING DEPENDENT CARE EXPENSES

By signing and submitting this Dependent Care Reimbursement Request form, 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 mentally incapable of caring for himself or herself.

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:
   (A) Your earned income: or
   (B) If you are married, your spouse's actual or deemed earned income (see below).
   [Your spouse is deemed to have monthly earned income of $200 ($400 if you are incurring dependent care expensed for more than one dependent), if your spouse either is a full-time student or is physically or mentally incapable of caring for himself or herself.]

4. Each dependent for whom you incur the expenses is:
   (A) A dependent under age13 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 caring for himself or herself.

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 8 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 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

8. 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 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.