

**Flexible Spending Accounts (FSA)
Request for Reimbursement**

The total amount of your Request for Reimbursement must be at least \$25.00 per account. See page titled, "Flexible Spending Accounts (FSA) Important Information" for further details.

Employee Information (Please Type or Print)

Name	_____
Office/Department	_____
SSN	_____
Home Address	_____
City, State, Zip	_____
Work Phone	_____
Home Phone	_____

Health Care Expenses (Attach Supporting Documentation)

Date of Expense	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Expense Amount
Total Health Care Expense Claim				

Employee Signature Required (Read Carefully)

I certify that all eligible expenses on this form for which I have requested reimbursement or payment were incurred while I was covered under the related Flexible Spending Account. I further certify that these expenses are not reimbursable under any other coverage. I understand that I am responsible for providing adequate, accurate and truthful information. If I knowingly submit an ineligible expense for reimbursement, that action could constitute fraud. In such cases, the reimbursement claim will be denied and I could be subject to disciplinary action, up to and including termination of employment. I further certify that I am aware of the postmark deadline of March 31 for submitting eligible expenses for the current plan year, and that expenses submitted after the March 31 plan year deadline will not be reimbursed. I also understand that I may be liable for any taxes related to these expenses if they are not eligible for reimbursement. I have read and understand the important information covered in the last pages of this form entitled, "Flexible Spending Accounts (FSA) Important Information".

Employee's Signature

Date

Send this form and supporting documentation to:

**Harrington Benefit Services
PO Box 2708
Dayton, OH 45401-2708**

Dependent Daycare Expenses (Attach Supporting Documentation)

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. See page titled, "Flexible Spending Accounts (FSA) Important Information" for further details.

Name of Dependent(s)	Service Dates		Name, Address, SSN or Tax ID Number of Service Provider	Expense Amount
	From	To		
Total Dependent Daycare Expense Claim				

You may complete the section above and attach a bill or a statement signed by the caregiver indicating the date the services were provided and the amount charged OR the caregiver may sign below and provide the necessary information.

I certify that I have provided dependent daycare as described on this form and noted above. I have received \$ _____ as payment for services I rendered for the above service dates.

Social Security # or Taxpayer ID # of Provider

Signature of Dependent Daycare Provider

Employee Signature Required (Read Carefully)

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Employee's Signature

Date

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Harrington Benefit Services
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Dayton, OH 45401-2708

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Health Care Expenses

Some examples of eligible expenses include health care plan co-payments and deductibles and vision, hearing, dental and prescription drug expenses not covered by insurance and not cosmetic in nature.

To request reimbursement of health care expenses complete the Flexible Spending Accounts Request for Reimbursement Form and attach the following documentation:

- If the eligible expenses are covered by your health care plan you must submit them under that plan first. When you receive your Explanation of Benefits (EOB) statement, attach it to this form, along with the itemized receipt, to claim amounts not paid by your health care plan. (An Explanation of Benefits (EOB) statement explains the benefits paid and charges not paid by your health care plan.)
- Orthodontia claims require a statement of medical necessity from the orthodontist. In addition, participants who claim the entire annual bill early in the plan year can receive only 50% reimbursement after the first appointment, with the balance being paid according to the schedule of service dates from the orthodontist. Participants who pay (and claim reimbursement) on an installment schedule consistent with their service appointments will not be affected by this provision.
- For all other expenses, attach an itemized original bill or receipt which shows the following information:

Name and address of provider of service or supply	ABC Drug Store 123 Hale Street Your Town & State	Date	Date of Expense
Name of service or supply furnished	Item Description: _____	Amount:	Expense Amount for service or supply
Name of person for whom expense was incurred	Item Purchased For: _____		

Dependent Daycare Expenses

In general the following rules apply to dependent daycare expenses:

- The expenses must be employment-related expenses for the care of an employee's dependent who is under age 13 and entitled to a dependent deduction under Internal Revenue Service Code Section 151(e) or a dependent who is physically or mentally incapable of caring for himself or herself.
- 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. If your spouse is either a full-time student or is incapable of taking care of him or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more.
- No payment may be made under the plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild who is under age 19.
- You cannot claim a tax reduction or tax credit for any expenses reimbursed through this account.
- If the services are provided by a dependent care center, the center must comply with all state and local laws and must provide care for more than six (6) individuals who are not residents of the facility.

Send Request for Reimbursement to:

**Harrington Benefit Services
PO Box 2708
Dayton, OH 45401-2708**

Telephone: (937) 226-8610

Inside Ohio: (877) 310-3539 Outside Ohio: (800) 222-2733