Section 125: FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST

Send This Completed Form To:
The Employee Benefit Services
P.O. Box 1803
Dublin, Ohio 43017
Phone: 614-764-4516
Facsimile: 614-793-9733

EMPLOYER

EMPLOYEE NAME

EMPLOYEE ADDRESS (NUMBER, STREET, CITY, ZIP CODE)

EMPLOYEE SOCIAL NO. EMPLOYEE DATE OF BIRTH EMPLOYEE PHONE NO.

I request reimbursement from the following account(s) established earlier this year.

☐ Medical Care Reimbursement Account

☐ Dependent Care Reimbursement Account

The services are qualified under the Plan and itemized below and my receipts or Explanation of Benefits are attached to document the services received.

Patient Name	Date Of Birth	Relationship To Employee	Date Of Service	Description Of Service(s)	Expense($)

I certify that I have not requested reimbursement under this Plan or from any other source for the above expenses. I also certify that the cumulative annual reimbursement request from the Dependent Care Assistance Reimbursement Account does not exceed my spouse's expected income or deemed income for the year.

I understand that I cannot claim expenses reimbursed under this Plan on my personal income tax return. I agree to reimburse the company for any liability it may incur for failure to withhold income tax or Social Security tax because of a non-qualifying reimbursement paid to me as a result of incorrect information provided by me.

I acknowledge that the expense(s) has (have) been incurred as substantiated by the attached documentation and that they have not been, or will not be, reimbursed by any other health Plan or other program.

Employee Signature: _____ **Date:** _____

Please file expenses covered by your medical, dental, or other plan with that employee benefit plan before requesting reimbursement through this plan.

Please attach receipts including name of service provider, date of service, detail of service and amount that you paid for the service.

FILING OF CLAIMS FOR FLEXIBLE SPENDING ACCOUNTS

The Reimbursement Request designed to provide an easy mechanism to file for unreimbursed medical expenses under your Flexible Spending Account. To reimburse you for your expenses, we need:

1. A completed Account Reimbursement Request (see other side), and,
2. A receipt for each claim stamped paid by the medical providers office and listing the patient name, physician name, charge and date of service, Or,
3. A copy of the Explanation of Benefits provided by an insured or self-funded medical plan.

To reimburse you for your dependent care expenses, we need a copy of a paid receipt from a qualified dependent-care provider.

We will complete reimbursement checks and pay you directly. **It is your responsibility to pay providers for any balance due.** It is important to complete all information on the form and attach receipts with the above information. Please send your Request For Reimbursement to:

Avalon Benefit Services
P.O. Box 1803
Dublin, Ohio 43017

For Speedy Submission Fax Claims To: 614-793-9733 or e-mail them to staff@avalonbenefits.com

FSA covered expenses are defined by Federal law, and a description of the common expenses covered is included below. For more detail, see your FSA Summary Plan Description.

FSA Oualifyine Medical Care Expenses

Under the Plan, you will be reimbursed only for those medical expenses generally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation). They include the services listed below when they are recommended by a physician to solve a medical problem:

1. Medicine, drugs, vaccines and vitamins prescribed by your doctor.
2. Medical care by licensed providers of care including MD's, dentists, chiropractors, osteopaths, psychiatrists, podiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts. Dental care provided by a licensed dentist and vision care provided by a licensed vision provider..
3. Medical examinations, x-rays and lab services, insulin treatment prescribed by a doctor.
4. Nursing help in your home or elsewhere.
5. Hospital care (including meals and lodging), clinic costs and lab fees.
6. Medical treatment at a center for drug addicts or alcoholics.
7. Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
8. Ambulance services and other travel costs to obtain medical care. If you use your own car, you can claim the cost of gas to and from the place of treatment or you can claim costs on a cents per mile basis. See IRS publications for the current cents per mile reimbursement level. Parking and tolls are also covered expenses.
9. Qualifying medical expenses for yourself, spouse and dependents listed on your federal return and any person that you could have listed on your federal return if that person had received $2,000 or less of gross income or had not filed a joint return.
10. Smoking cessation programs to help you stop smoking.
11. Weight loss programs.
12. Laser surgery to correct eyesight problems.
13. Many other services that are too numerous to list. See the web site link below.

You cannot obtain reimbursement for: premiums incurred by your spouse for accident or health insurance, the basic cost of Medicare Insurance, life insurance or income protection policies, the hospital insurance benefits tax withheld from your pay as part of Social Security tax, nursing care for a healthy baby, illegal activities and travel prescribed by your doctor for the purpose of rest or change.

Note: See IRS Publication 502 at www.IRS.,gov for a more detailed explanation.