M *Flexible Benefits Plan*
MEDICAL CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS, INC.**

Employee Information

CHECK BOX IF NEW ADDRESS ☐

Please also notify employer of any address changes.

Employee Name _____ SSN _____
Last First MI

Employer _____ Employee ID (if known) _____

Home Address _____
Street City State Zip

Email Address _____

Home Phone (_____)_____ Work Phone (_____)_____
area code area code ext.

Expenses

Please list all out-of-pocket unreimbursed eligible medical expenses, as defined in the Summary Plan Description (SPD), for which you are requesting reimbursement.

Description of Expense	**Date of Service**	**Amount***

*Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, Workers' Compensation, or any other policy of health insurance.

TOTAL EXPENSES $_____

Include with this form all "Supporting Documentation" as defined in the Important Information section on the reverse side of this form. Retain a copy for your records. Canceled checks are not acceptable. Failing to submit Supporting Documentation will delay (or prevent) claims processing.

Employee Certification

By submitting this form, I hereby certify the following:

- All expenses identified above are "Eligible Medical Expenses" as defined in the SPD (Note: You can find general information regarding Eligible Medical Expenses in the Important Information section on the reverse side).
- All expenses were incurred by me (the employee), my legal spouse, or an eligible dependent as defined in the SPD (Note: You can find general information regarding the definition of legal spouse and eligible dependents in the Important Information section on the reverse side).
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I will not deduct the above listed expenses on my personal federal and/or state income tax return for any year. My employer does not accept responsibility for direct payment to any individuals other than the employee.

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Please SIGN

Employee Signature _____ **Date** _____

IMPORTANT INFORMATION

Please note: Nothing in this section is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between this section of the Form and the SPD, the SPD controls.

Eligible Medical Expenses - In general, only expenses for "medical care" as defined in your SPD are eligible for reimbursement under the Medical Care Reimbursement Account (as defined in Code Section 213(d) with notable exceptions). IRS Publication 502 (available at www.irs.gov) summarizes medical expenses allowable as deductions for tax purposes. Publication 502 states as allowable some expenses which ARE NOT reimbursable under a Medical Care Reimbursement Account (for example, insurance premiums). In all situations, only medical care expenses not reimbursed from any other source are reimbursable.

Examples of eligible expenses include co-payments/deductibles, vision, hearing, dental, over-the-counter drugs and most uncovered prescription drug expenses. Examples of ineligible expenses include insurance premiums, vitamins/supplements for general good health, cosmetic procedures and products, and counseling not related to a medical condition.

Legal Spouse and Eligible Dependents - Only eligible medical expenses incurred by you, your "legal spouse" or "eligible dependents" (as defined in the SPD) are eligible for reimbursement. Generally, your legal spouse is your spouse as recognized by federal law. Your eligible dependents include any individual who would qualify as an eligible dependent as defined in Code Section 105. Consult with a qualified tax or legal counsel to determine if expenses incurred by individuals for whom you request a reimbursement qualify as your legal spouse or eligible dependents.

Supporting Documentation - For all expenses, attach bills or evidence of charges that clearly state all of the following:

1. Name of person receiving service (except for over-the-counter products)
2. Name of service provider
3. Nature of service or supplies (drug name if a prescription or over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

Medical and dental expenses covered partially by your health care plan(s) are generally allowable. Explanation of Benefits statements which contain the above information may be submitted as supporting documentation. For over-the-counter products, provide a cash register receipt with product information or include a copy of the box/bottle with cash register receipt. In many instances, you may be required to provide additional substantiation as determined by the claims administrator. For example, a doctor's note may be required for some expenses to verify that the expense qualifies as medical care.

Medical Practitioner's (Doctor's) Notes - For some expenses, a medical practitioner note is required to verify that the expense qualifies as medical care. To be allowable, a medical practitioner note may be written by a doctor of medicine, dentistry, podiatry or optometry; an authorized chiropractor, an alternative healer; or other qualified medical practitioner. A medical practitioner note must contain all of the following items: 1. date; 2. patient's name; 3. medical practitioner's name; 4. statement of medical necessity; 5. the prescribed treatment; and 6. the duration of treatment required.

Cosmetic procedures (for example, teeth bleaching) and drugs (prescription and nonprescription) to be used for a cosmetic purpose are not reimbursable. Under the plan, medical care "does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease." Expenses for transportation primarily for, and essential to, medical care are reimbursable. For such expenses, information must be provided that states the nature of medical care (for example, "doctor's appointment") and the date service was provided.

Orthodontia expenses can be reimbursed in one full sum or in monthly installments. Proper documentation of procedure and payment plan must accompany each claim form. For orthodontia expenses to be eligible, payment must have been made within the current plan year.

Submission of Reimbursement Requests – Fax (preferred), email or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable.

Please note - Service dates for reimbursable expenses must fall within the plan year (or during the grace period if adopted by the employer). Expenses incurred before participation began or after participation has terminated will not be reimbursed. After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.

CROSBY
Benefits People