



HEALTH CARE REIMBURSEMENT REQUEST FORM

EMPLOYEE INFORMATION

NAME _____ **DEPARTMENT** _____ **EXTENSION** _____

Instructions: Complete the information below for Health Care Expenses incurred by you, your Spouse or other eligible Dependents. (For information as to what Health Care Expenses can and cannot be reimbursed, and for the special rules that apply to claims for expenses incurred during any Grace Period for which you may be eligible, see the Plan Document.) You must provide insurance EOB's, hospital or doctor bills, pharmacy receipts, or other evidence from independent third parties that the Expenses were incurred (canceled checks or credit card receipts will not be accepted). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you. Please date and sign the Form, then send it along with your supporting documentation to the Human Resources Department.

| SERVICE PROVIDER | DATE OF SERVICE | NAME OF RECIPIENT OF SERVICE AND THEIR RELATIONSHIP TO YOU | TYPE OF SERVICE PROVIDED | REIMBURSEMENT REQUESTED |
|------------------|-----------------|--|--|-------------------------|
| | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent _____ (NAME) | <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental | |
| | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent _____ (NAME) | <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental | |
| | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent _____ (NAME) | <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental | |
| | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent _____ (NAME) | <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental | |
| | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent _____ (NAME) | <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental | |

TOTAL REIMBURSEMENT REQUESTED:

\$ _____

I authorize the above expenses to be reimbursed from my Health FSA Account. To the best of my knowledge, my statements in this Form are true and complete. I certify all the following: Either I have or my family member has received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Health Care Expenses under the Plan. These expenses are for health care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. If the expense is for my Spouse or Dependent, the person listed is my Spouse or Dependent as defined in the Plan. I have not been reimbursed previously for these expenses under the Health FSA or any other plan and I will not seek reimbursement for them under the Medical Insurance Plan or any other health plan. In addition, I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g. a medical practitioner's statement that an expense is to treat a specific medical condition or a more detailed certification from me). I understand that if my claim is for expenses incurred during a Grace Period: (1) the expenses will be reimbursed first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year; (2) claims are paid in the order in which they are approved; and (3) once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it.

EMPLOYEE SIGNATURE

DATE

FOR EMPLOYEE BENEFITS DEPARTMENT USE ONLY

The expenses itemized above have been reviewed and approved for payment.

ADMINISTRATOR

DATE APPROVED

IRS and/or program regulations

1. Original or photocopies of original receipts must be submitted with the City's reimbursement request form(s). All receipts must clearly show the date of service as verified by an independent third party. (i.e. the pharmacy, the doctor's office, etc.) This includes mileage reimbursements.
2. Unless I am exhausting the balance of my account, my reimbursement request must be for a minimum of \$25.00.
3. It is my responsibility to clearly identify expenses on the reimbursement request form I submit, including an accurate calculation of the totals. Incomplete or inaccurate reimbursement request forms may be returned to me, which may cause my reimbursement to be delayed or denied.
(Multiple receipts with the same date of service, same provider, same patient can be listed on one line of the reimbursement request form. Otherwise, items need to be listed separately.)
4. Reimbursement request forms are requested no later than 5:00 p.m. on Monday. The intention is to write checks each Wednesday. Last minute submission of a reimbursement request may result in a reimbursement on the following Wednesday.
5. The Human Resources Department has the right to request additional documentation to support the reimbursement request, which may result in a delayed or denied reimbursement. If a reimbursement request is denied, an appeal may be made first to the Human Resources Director then to the City Administrator, if necessary, whose decision is final.
6. All receipts must clearly identify the service/product provided. If a receipt does not clearly specify the service/product, additional documentation by an independent third party must accompany the receipt. Such documentation may include the box with the price tag matching the receipt. "Stocking up" of products at the end of the year is not allowed. There must be a reasonable assumption that the product will be used in the tax year in which it was purchased.
(For confidentiality reasons, you may remove the name of the drug from prescription receipts, as long as it is clear that the amount on the receipt is your portion of the prescription cost, not your insurance company's. For example, the prescription receipt is for your co-pay only.)
7. I understand that I cannot change or revoke this Agreement with an effective date prior to next January 1, unless a Change in Election Event occurs and all conditions to changing my election are satisfied, as provided in the Plan document.
8. I understand that any amount remaining in my Health FSA account after reimbursing my Health Care Expenses for the Plan Year, and any applicable Grace Period, will be forfeited.
9. I must re-enroll in the Health FSA program annually to continue my participation in the program.
10. Orthodontia expenses, even if fully pre-paid, will only be reimbursed over the time of the treatment schedule. Initial "down payments", or the equivalent if fully pre-paid, are eligible for reimbursement at the time of the first orthodontia treatment appointment.
11. Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. I understand that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
12. The Health FSA program is offered in accordance with IRS rules and regulations. As such, I acknowledge that there may be cases where Highly Compensated Employees may need to report some of the income from their Health FSA account on their income taxes. I can contact the Human Resources Department for additional information.