State of Colorado Reimbursement Request Form

Please read **requirements** on reverse side

Last Name, First Name, MI (Please Print) | Day Time Phone No. | Social Security Number

Street Address | City, State, Zip

Dependent Day Care Expenses

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	age	Dates Care Provided From	Dates Care Provided To	Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period		ASI use only
				Total Dependent Day Care Amount Requested			

I provided the dependent care as stated above.

Care Provider's **original** signature | Date | SSAN/Tax ID#

Health Care Expenses

Date Medical Care **Provided**	Name of Medical Provider	General Medical Expense Description	Name and relationship of Person for Whom Expense Incurred	Amount that is your responsibility	ASI use only

Total Health Care Amount Requested _____

Please arrange documentation in order listed above.

Claims for future services will not be accepted.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the State of Colorado Flexible Spending Account Plan with respect to such expenses and that the expenses have not been reimbursed and will not be reimbursed from any other source. Any Dependent Day Care Expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_mployee's Signature | Date

Central/ASI
P. O. BOX 6044
COLUMBIA MO 65205-6044

~- Mail to Central/ASI **ALONG WITH SUPPORTING DOCUMENTATION**
E-mail: asi@asiflex.com
Internet http://www.asiflex.com
InfoLine 125: 1-800-366-4827

Claim Filing Requirements

Print your name, address, and social security number.

List expenses *by* ***date & arrange the supporting statements in the same order.*** Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.

Day care claims - complete the Dependent Day Care Expenses section

Health care claims - complete the Health Care Expenses section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

Enclose required documentation*. A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing:

The name of the dependent care or medical service provider,

The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.

A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),

The name of the person or persons receiving the medical or dependent care, and

The cost of the service, not just the amount paid.

***Dependent Day Care claims only. -** You may either provide documentation from the day care provider or have the provider complete the Dependent Day Care Expenses Section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

Requests filed without the above documentation cannot be processed and will be returned.

Sign the claim form.

Keep copies for your tax records.

Mail to the address on the front of this form.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.

Claims payment and account information available 24 hours a day 7 days a week: - Complete history including available funds *on the Web* at *www.asiflex.com* (Account Detail). You will need your P.I.N., which you can find on your enrollment confirmation. *InfoLine* - last two payments plus available funds. Call 1-800-366-4827 from a touch-tone phone.

Claim forms: You may copy this form. Obtain forms on the Internet at http://www.asiflex.com. Call customer service at 1-800-659-3035 or e-mail us at asi@asiflex.com.