Franciscan University

Flexible Spending Reimbursement Request

FOR EXPENSES INCURRED AFTER JANUARY 1, 2009

Before completing this form, read instructions on reverse side.

❶ Employee Information

_____ _____-_____-_____

Employee Last Name, First, Middle — Social Security Number

_____

Street Address, City, State, Zip

Is this a new address since your last request for disbursement? ☐ Yes ☐ No

❷ Health FSA Expenses

I request reimbursement of the following health expenses which qualify for myself and my dependents:

Provider of Service	Date of Service	Total Charge	Amount Paid by Other Sources	Amount to be Reimbursed
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
_____	_____/_____/_____	$_____	$_____	$_____
			TOTAL:	$_____

❸ Day Care FSA Expenses

I request reimbursement of the following day care expenses which qualify under the plan:

Name of Dependent	Age	Provider of Service and EIN/SSN of provider	Date of Service FROM	Date of Service TO	Amount to be Reimbursed
_____	_____	_____	_____/_____/____	____/____/____	$_____
_____	_____	_____	_____/_____/____	____/____/____	$_____
_____	_____	_____	_____/_____/____	____/____/____	$_____
_____	_____	_____	_____/_____/____	____/____/____	$_____
				TOTAL:	$_____

❹ Employee Signature

The information furnished by me in support of this application is true and correct to the best of my knowledge.

I understand that these expenses must qualify under applicable sections of the Internal Revenue Service Code and certify that they are not eligible for reimbursement under any other source.

I hereby authorize any individual or organization to release any information requested by EBDS with respect to this specific application.

_____ (_____)_____ _____/_____/_____

Employee Signature — Phone Number (During business hours) — Date

Mail Completed form and documentation to: **EBDS Flex Claims, Account Service Center, P. O. Box 22130, Pittsburgh, PA 15222**

/j:flex/fran fsa claim form.doc

Flexible Spending Reimbursement Request
INSTRUCTIONS

- Use this form as a request for disbursement of expenses incurred during the plan year.
- If you are submitting expenses for more than one plan year, you must submit a separate form for each year that you are an eligible participant. Complete all information, and be sure to sign the reimbursement request in Section 4.
- Each expense you submit must be properly documented.
- Attach all documentation securely to the form and retain copies for your records.
- Mail completed form and documentation to: EBDS Flex Claims, One Gateway Center, Suite 1100, 420 Fort Duquesne Blvd, Pittsburgh, PA 15222-1416; Phone: 1-800-207-9310.

❶ Employee Information

Please print or type all information.

❷ Health FSA Expenses

Each expense that you submit for reimbursement must be properly documented. Acceptable forms of documentation include Explanation of Benefits Forms (EOB) from insurance companies, and itemized bills from providers of services.

An itemized bill from a provider must be on the provider's letterhead or billing form, and must include the following information: name of provider, address of provider, name of patient, date of service, description of service or item, and amount charged for service.

Bills for prescription drugs and eligible equipment, appliances or supplies must include the above information.

Only EOBs and itemized bills will be accepted. Bills showing "Balance Forward", "Amount Due", Paid on Account" or similar wording, are not acceptable. **Credit card receipts and cancelled checks are also not acceptable forms of documentation.**

❸ Day Care FSA Expenses

Eligibility Requirements. . .

The expenses are either (1) for household services attributable to the care of a "qualifying individual"; or (2) for the care of a "qualifying individual" outside your home by an individual or at a facility. *(If care is provided outside your home for more than six individuals at a single location, that location is treated as a dependent care center and must comply with applicable state or local regulations.)* Transportation expenses are not reimbursable. Expenses for education, food, and lodging are reimbursable only if they are incidental to the care of a dependent. Educational expenses for a child in kindergarten or higher grades are not eligible for reimbursement.

A Qualifying Individual Is. . .

- A dependent of the Flexible Spending Account participant who is under age 13 and with respect to whom you are entitled to a deduction on your federal income tax return. *(If you are divorced or legally separated, the requirement that the child be an exemption deduction does not apply if you have custody of him or her for more time during the year than the other parent.)*
- An individual *(e.g., a parent or child age 13 or older)* who resides with you, who is physically or mentally incapable of self care, and who you claim *(or able to claim)* as a dependent on your federal income tax return.
- A spouse who is physically or mentally unable to care for himself or herself.

The expenses must be for the purpose of allowing you (and if married, your spouse) to be gainfully employed during the period when you are responsible for the qualifying individual.

If married, the amount of reimbursable expenses for a taxable year will not exceed the lesser of your earnings or your spouse's earnings for that taxable year. If your spouse is a full-time student, or physically or mentally unable to care for himself or herself, your spouse is deemed to have earnings of $200 a month ($400 a month if you have two or more qualifying individuals). If you are not married at the end of the year, the limitation on reimbursement will be based on your earned income for that year.

Documentation Requirements. . .

Each expense that you submit for reimbursement must be properly documented. Acceptable documentation for a dependent care claim is an itemized bill from the provider of services.

An itemized bill from a provider must be on the provider's letterhead or billing form and must include the following information:

- Name of dependent
- Dates of service
- Description of service or item
- Amount charged for service
- Name of Provider
- Provider's EIN or SSN
- Provider's address

❹ Employee Signature

Please be sure to sign the form and provide a number where you can be reached during business hours.