EBS | ATLANTA | LOS ANGELES

MAIL YOUR CLAIM FORM TO -

EBS/ATLANTA

2500 NORTHWINDS PARKWAY, SUITE 400

ALPHARETTA, GA 30009

or FAX YOUR CLAIM TO (770) 569-0211

CLAIM FORM –
REQUEST FOR REIMBURSEMENT

PART 1 – EMPLOYEE INFORMATION *(This form is interactive & may be completed by tabbing through each field)*

Employee's Name____________________ Social Security Number ________________

Home Address____________________ Group Name *(Employer)*________________

City/State/Zip____________________ Daytime Telephone ________________

Check here if this is a new address

PART 2 – FOR WORK-RELATED DEPENDENT CARE EXPENSE CLAIMS (Dependent Day Care or Elder Care – not medical expenses)

Name and Relationship of Dependent(s) for Whom Service was Provided	*Date Service Provided*		*Name and Address of Service Provider*	*Cost of Service*
	From	*To*		
			Total Dependent Day Care Expenses Claimed	

NOTE: Only work-related dependent care expenses are eligible for reimbursement. Child care is for individuals under age 13. Care for individuals over the age of 12 years old may be reimbursed only if the individual is disabled and otherwise incapable of self-care and only if the individual may be claimed by the Employee as a dependent for federal income tax purposes. The total amount claimed under the Dependent Day Care Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year of the earned income of your spouse. (If your spouse is either a full-time student or is incapable of self-care, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent and $400 if there are two (2) or more.) No payment may be made under this Plan if the service provider is your dependent for federal income tax purposes or is your child or stepchild and is under age 19.

PART 3 – FOR UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Service Provided	*Name of Service Provider*	*Description of Expense*	*Name and Relationship of Person for Whom Service was Provided*	*Amount Which You Are Responsible*
			Total Medical Care Expenses Claimed	

NOTE: You must attach a copy of the documentation from your service provider or insurance company showing the date of service, a description of the service provided, the name of the person for whom the service was provided, and the amount for which you are responsible. Please read the attached Claims Filing Instruction Page for additional information concerning proper documentation.

PART 3 – EMPLOYEE'S SIGNATURE *(Required)*

The expenses claimed above are true and correct to the best of my knowledge and belief. I agree that the Plan will have the right to recover any reimbursement made to me for any expense found to be false or otherwise ineligible for reimbursement under IRS guidelines and that I may be liable for payment of all related taxes including federal and state income tax on the amount paid from the Plan which relate to such expense. I certify that the expenses claimed have not nor will be reimbursed from any other source. I understand that any expense reimbursed under this Plan may not be claimed as a deductible expense on my federal or state income tax return.

X____________________ Date________________

Please Read the *Claims Filing Instruction Page* for Important Information

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Please Read Carefully

CLAIM FILING INSTRUCTIONS

Who May File A Claim Form

- Only employees participating in the Plan may file a Claim Form.
- Participating employees may file a Claim Form during the Plan Year and for a certain period after the Plan Year ends (please refer to your Summary Plan Description, Plan Overview, or Reimbursement Schedule for your organization's Plan Year and filing dates).
- Terminated employees may file a Claim Form for a certain period after the date of termination as described in the Summary Plan Description or Plan Overview.

Expenses That May Be Claimed

- Only expenses for services actually provided during the Plan Year may be claimed for reimbursement. The ***actual date of service*** determines the date for reimbursement eligibility and not the date you paid for the service or the date you were billed for the service.
- Each Plan Year is treated separately. Expenses may not be carried forward from one Plan Year to the next.
- Expenses eligible for reimbursement are generally the same as those allowed for tax purposes
- **Only expenses not paid or reimbursed by insurance or any other source, may be claimed.** Additionally, expenses reimbursed under this Plan ***may not*** be claimed as a deductible expense on the employee's federal or state income tax return.

Completion of the Claim Form

- You must complete **all** information on the Claim Form for each amount claimed for reimbursement.
- You **must** complete ***Part 1 – Employee Information*** and you **must** sign and date your Claim Form.
- Make sure your Claim Form does not include items for more than one Plan Year. Use separate Claim Forms for each Plan Year.
- Make sure your Claim Form does not include expenses for services provided prior to the beginning of the applicable Plan Year or prior to your date of entry into the Plan, whichever is later.
- **Proper documentation to substantiate your claim must be attached to your Claim Form. *See below -***

TO CLAIM MEDICAL EXPENSES

Proper evidence of your expense must be provided by an independent third party, such as an insurance company or the service provider.

ACCEPTABLE DOCUMENTATION

- Co-Pay receipt from your HMO or POS health plan or pharmacy
- Explanation of Benefits (EOB) from your insurance company
- Itemized Statement from the provider if your expense is not covered by insurance *
- Prescription drug tax receipt if your health plan does not include a prescription card or copay feature **

NOT ACCEPTABLE

- Balance Forward Statement
- Credit Card/Charge Receipts
- Cash Register Receipts that are not electronically itemized
- Canceled Checks
- Receipts showing "Paid" or "Received on Account"

* **Itemized Statement must be from the service provider and must include the provider's name, address, and telephone number, a description of the service provided, the date the service was provided, the name of the person for whom the service was provided, and the dollar amount of the expense.**

** **Prescription drug receipts must include the name of the pharmacy, the name of the drug dispensed, the person for whom the drug was prescribed, and the co-pay or cost of the drug.**

Federal Regulations prohibit your Plan from reimbursing any expense that has been paid or will be paid by insurance or through any other source. If the expense is a covered expense under any insurance policy, it should first be filed with the insurance carrier prior to submission for reimbursement.

Additional Information Concerning Eligible Health Care Expenses

- Click here to download a copy of ***"Your Medical Flexible Spending Account"***
- Click here to download a copy of ***IRS Publication 502, "Medical and Dental Expenses"***
  (Please note, IRS Publication 502 defines medical and dental care expenses that a taxpayer may or may not claim as a deduction on the taxpayer's federal income tax return. Most, but not all, of the expenses listed in Publication 502 may be eligible for reimbursement. Some expenses listed in Publication 502 as being eligible as a deduction ***may not be reimbursable under this Plan.*** However, any expense listed in Publication 502 as being ineligible to be taken as a deduction on a taxpayer's federal income tax return, will not be considered under any circumstances as eligible for reimbursement under this Plan, You may rely on IRS Publication 502 as a guide, however, **if you question whether an expense may be eligible for reimbursement, you should always check with EBS/Atlanta concerning the eligibility of the expense before electing to contribute to a Medical Flexible Spending Account**)

TO CLAIM DEPENDENT& ELDER CARE EXPENSES

- Only work-related dependent care expenses are eligible for reimbursement.
- Child care is for individuals age 12 and under. Care for individuals over age 12 (including elder care) may be reimbursed only if the individual is disabled or otherwise incapable of self-care and only if the individual may be claimed by the Employee as a dependent for federal income tax purposes.
- You must complete all information under ***"Part 2 – Dependent Care Expense Claims"*** on the Claim Form.
- You must provide a completed **IRS Form W-10** for each dependent care provider you use during the Plan Year.
- Overnight camp, nursing homes, or educational expenses are ***ineligible and may not*** be claimed for reimbursement.

Additional Information Concerning Dependent & Elder Care Expenses

- Click here to download a copy of ***"Your Dependent Care Flexible Spending Account"***
- Click here to download a copy of **IRS Form W-10, *"Dependent Care Provider's Identification and Certification"***
- Click here to download a copy of **IRS Publication 503, *"Child and Dependent Care Expenses"***