Benefits Outsource

Your Outsource Resource™

Flexible Spending Accounts Health Care & Dependent Care (Plan Year 2013 - 2014)

Reimbursement Form

Customer Service 954-680-7626 or 1-888-877-2780

Part I: Employee Information (Please Print)

Employee Name (Last, First, MI)	Telephone # (Day)	Employee SSN

Employee Home Address	City	State	Zip Code

Part II: Health Care Expenses

Patient's Full Name	Relationship	Birth Date	Service Date From / To	Service Type(s) (Medical, Dental, Vision)	Reimbursement Request Amount
1.					
2.					
3.					
4.					
5.					
				Total	

Part III: Dependent Care Expenses

Dependent's Full Name	Birth Date	Service Date To / From	Reimbursement Requested Amount
1.			
2.			
3.			
4.			
		Total	

Provider's Name and Address	Provider's Tax ID # or SSN

Part IV: Affidavit of Dependent Care Services Rendered

I have provided adult/child care for _____ for the period beginning _____

and ending _____ 20_____. Services were provided to _____ for a fee of _____.

Care Giver Signature _____Tax ID# or SSN# _____ Date _____

Part V: Employee's Certificate for Reimbursement

By my signature below, I hereby certify that the reimbursement benefit that I am claiming on this Flexible Spending Account Reimbursement Claim Form has not and is not expected to be recovered under any other insurance plan or arrangement. I understand that if I recover benefit from another insurance plan or arrangement, consequently, I will be solely and singularly responsible for any taxes or other penalties resulting from such reimbursement.

Employee Signature_____ Company Name: _____Date _____

BENEFITS OUTSOURCE, INC.
5599 S. UNIVERSITY DRIVE, SUITE 201
DAVIE, FL 33328

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Flexible Spending Accounts Health & Dependent Care Reimbursement Claim Form

Customer Service 954-680-7626 or 1-888-877-2780

General Instructions

Please read these instructions before completing the information requested on the Reimbursement Claim Form.

1. Complete all information requested under Part I, "Employee Information".
   Where applicable, complete Part II, "Health Care Expenses" and/or Part III, "Dependent Care Expenses".

2. This form should be used to request reimbursement for the following:

Health Care Expenses

A. Expenses not covered by any benefit plans for you and/or your dependents, relating to medical, dental or vision plans, allowed by governing rules. Each amount must be substantiated with an Explanation of Benefits form (EOB), or receipts that indicate the following:

a. Provider and type of service or product provided

b. Date the expenses were incurred

c. Name of employee and/or dependent for whom the services or products were provided

d. Expense amount

B. Cancelled checks alone do not constitute proper supporting document for such expenses, the above requested information must accompany cancelled checks.

Dependent Care Expenses

A. Generally, the following rules apply to dependent care expenses:

a. Dependent care expenses qualify if they are for the care of children or other dependents who are physically or mentally unable of caring for themselves. Such expenses must be incurred so that you and your spouse, if married, can work or attend school full-time.

b. Children must be under the age of 13.

c. Services provided by a childcare or elderly care center must comply with all state and local laws to be eligible reimbursement expense.

B. The annual amount of dependent care claims cannot exceed:

a. The annual deposit amount of $5,000 ($2,500 if you and your spouse are filing separate returns, or

b. Your annual salary or your spouse's annual salary, if less than $5,000.

C. All allowable day care expenses must be supported by the bill or signed receipt, or the provider may complete Part IV, "Affidavit of Day Care Services Rendered" on reimbursement claim form. Requests for reimbursement of Dependent Care expenses will not be processed without the Tax ID number for all providers.

3. Part V, "Employee's Certification for Reimbursement" statement should be read, signed and dated prior to submission for reimbursement. Make sure the Company name is specified as well.

4. Please email or mail the completed form and supporting documents to: benefits@boibenefits.com or Benefits Outsource, Inc., FSA Claims Processing Dept., 5599 S. University Drive, Suite #201, Davie, FL 33328.

Should there be any questions, please call us at 1-888-877-2780 or (954) 680-7626.