Section 125 Flexible Benefit Reimbursement Voucher

First Financial Administrators, Inc.

First Financial Administrators, Inc.
First in Service and Expertise

EMPLOYEE INFORMATION *(Please Print)*

ADDRESS CHANGE? ☐ Y ☐ N

FIRST NAME	MI	LAST NAME	SSN

ADDRESS	CITY	STATE	ZIP

PHONE *(Between Hours of 8am-5pm)*	EMPLOYER	EMAIL ADDRESS

PROVIDER INFORMATION

COMPLETE ONLY FOR DEPENDENT CARE PROVIDER

NAME:_____
ADDRESS:_____
CITY:_____ ST:_____ ZIP:_____
SSN:_____
TAX ID:_____

_____
Signature of Provider

COMPLETE ONLY FOR ORTHODONTIA REIMBURSEMENT

NAME:_____
AMOUNT DUE:_____ DATE:_____
SERVICE PERFORMED:_____
I certify that the dental procedure for the above patient:
☐ HAS BEEN COMPLETED ☐ IS IN PROGRESS

_____
Signature of Dentist/Orthodontist

BENEFIT TYPE *(please check as appropriate)*

☐ MEDICAL REIMBURSEMENT ☐ DEPENDENT CARE REIMBURSEMENT ☐ PREMIUM REIMBURSMENT

DATE OF SERVICE	FAMILY MEMBER	DESCRIPTION OF EXPENSE	AMOUNT

☐ Please send me additional envelopes *(additional voucher given with every reimbursement)*

TOTAL: $ 0.00

Mail or Fax Completed Form To:
First Financial Administrators, Inc. • P.O. Box 670329, Houston, TX 77267- 0329
Fax Number: 1-800-298-7785

IMPORTANT NOTICE: Effective January 1, 2011, all over-the-counter items eligible for reimbursement must be accompanied by a doctor's prescription and a reimbursement voucher.

EMPLOYEE SIGNATURE *(REQUIRED)*

I hereby affirm that, to the best of my knowledge, all expenses listed above are eligible for reimbursement under Section 105(h) or 129 of the IRS Code and in accordance with my contract with First Financial Administrators, Inc. I further certify that these expenses have not been, nor will not be, reimbursed under any other health plan coverage.

NOTE: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for Insufficient funds. Please call your financial Institution to verify deposit before writing any checks on the amount. If you need verification of the eligibility of an expense, please contact First Financial Administrators, Inc. at 1-866-853-3539. See reverse side for submission guidelines.

EMPLOYEE SIGNATURE:_____ DATE_____

First Financial Administrators, Inc.
PO Box 670329 • Houston, TX 77267-0329
Phone: 866-853-3539 • Fax: 800-298-7785

See www.ffga.com for more information about Flexible Spending Accounts

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SUBMISSION GUIDELINES

MEDICAL REIMBURSEMENT SUBMISSION GUIDELINES:

Acceptable documentation to accompany the reimbursement voucher:

- Professional bill or receipt that includes:
  - » Provider of service
  - » Type of service rendered
  - » Original date of service
  - » Charges for the service
- Insurance company Explanation of Benefits
- Pharmacy statement that includes Rx number and name of the prescription

DAYCARE SUBMISSION GUIDELINES:

Acceptable documentation to accompany the reimbursement voucher:

- Vouchers for Dependent Care signed by the Provider. Voucher must also be completed with the Provider's tax identification number or Social Security number and dates of service, or;
- Voucher with receipt from Provider, including Provider name, Provider signature, dates of service, amount for service, and tax identification/social security number.

I.R.S Regulations prevent us from reimbursing dependent care yearly contracts. Monthly submissions are required.

UNACCEPTABLE DOCUMENTATION

- Canceled checks / Credit card receipts
- Bill or receipt that only shows a balance forward or previous balance
- Cash register receipt

Note: It is important to note that the date of service, not the date of payment, must fall within the dates of the plan year for which you are enrolled.