INSTRUCTIONS

Health Care Reimbursement Account

1. Health Care Eligible Expenses: In general, an employee may be reimbursed for a health care expense which qualifies as a deduction on the federal income tax return, but which has not or will not be reimbursed by any other source and has not been or will not be deducted on the employee's income tax return. Some examples of eligible expenses are: deductible, coinsurance, dental, vision, hearing, and any medical expense not covered under your health plan, i.e., routine care, prescription birth control.

Employee contributions toward health premiums, disability, life and cancer coverage premiums, have already been processed by your employer and do not need to be submitted.

2. Supporting documentation: The following supporting documentation must be attached to this form:

   - Health care expenses not covered by your health care plan. For all expenses, attach bills that clearly state:

     - Name of person receiving the service
     - Nature of service or supplies
     - Name and address of provider of service
     - Amount charged
     - Date service was rendered

   - Expenses covered by your health care plan: Medical expenses covered by your health care plan must be submitted under that plan first. A copy of the explanation of benefits statement which you receive is all you need to submit.

Dependent Day Care Reimbursement Account

1. Dependent Care Eligible Expenses: In general, the following rules apply to dependent care expenses:

   - The annual amount submitted for reimbursement cannot exceed the earned income of the lower paid spouse.
   - The expenses must be employment-related expenses for the care of a dependent of the employee who is under age 13 and entitled to a dependent deduction under Internal Revenue Service code section 151(e) or a dependent who is physically or mentally incapable of caring for himself or herself.
   - The payments cannot be made to a person who is claimed as a dependent by the employee.
   - If the services are provided by a dependent care center must comply with all state and local laws and must provide care for more than six individuals (other than a resident of the facility).
   - Day care expenses should not be submitted more often than monthly.

2. Supporting Documentation: The following supporting documentation must be submitted for dependent day care reimbursement:

   - Dependent Name/Relationship
   - Date(s) of service
   - Age
   - Amount Charged
   - Tax ID

All claims must be in our office **5 working days** prior to your Scheduled check run

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

For faster service, fax claims to: (919) 562-0021
Or mail to: IMS Flex Department, PO Box 1349 Wake Forest, NC 27588

Today's Date: ________ / ________ / ________ Total # of pages: ____________

EMPLOYER : ______________________________ GROUP # ______________

EMPLOYEE NAME ______________________________ SS # ______________

New Claim ☐ Resubmission of Claim ☐ Flex Debit Card Documentation ☐

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MEDICAL REIMBURSEMENT

- Attach copies of receipts, itemized bills from the provider showing the date of service, services rendered, provider of service, amount paid, and if applicable, amount covered by insurance and retain copies for your records.
- Prescription drug claims MUST include the RX number on the pharmacy receipt, not the cash register receipt.
- Eligible qualified over the counter medications must be substantiated by an itemized description on the store receipt.

	Total Amount Requested	Dates of Services
UNREIMBURSED MEDICAL, DENTAL, VISION, etc:	$ ______________	From________ To ________
DEPENDENT DAY CARE:	$ ______________	From________ To ________

I also certify that the total DEPENDENT DAY CARE expenses (if any) for which I am requesting reimbursement do not exceed the lesser of my or my spouse's earned income for the plan year. I understand that reimbursed expenses can not be claimed on my personal income tax return. Also, any unused funds in my account at the end of the plan year will be forfeited.

I certify that this information is correct, complete and meets all requirements for eligible health care and dependent care expenses.

______________________________ ______________________________
EMPLOYEE SIGNATURE DATE

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DEPENDENT CARE REIMBURSEMENT

(Maximum yearly amount is $5,000 for married individuals filing joint returns and for single individuals, or $2,500 for married individuals filing separate returns.)

*Day care provider must complete Affidavit if you do not have an actual paid receipt.

STATEMENT OF DAY CARE PROVIDER

I have provided child/adult care for ______________________________ ______________
(DEPENDENT NAME) **(AGE)**

For the period beginning ______________________ and period ending ______________________
(DATE) **(DATE)**

Services were provided to ______________________________ for fee of $ ______________
(EMPLOYEE NAME)

PROVIDER NAME______________________________ ______________________________
(SIGNATURE)

ADDRESS ____
(DATE)

PHONE ______________________________ TAX ID (Required) ______________________