REQUEST FOR REIMBURSEMENT FORM – FLEXIBLE SPENDING ACCOUNT PLAN

Employer:		**Last 4 Digits of SS#:**	
Employee Name:		**Phone Number:**	
Home Address:	☐ Check this box if this is a NEW address	**Email Address:**	

Claim Submission Instructions: To seek reimbursement for your FSA expenses, please complete the information below for eligible expenses incurred by you, your spouse or other eligible dependents. **You must provide itemized/detailed documentation of the service/purchase from the provider, your insurance Explanation of Benefits (EOB) or other third-party documentation that the expenses were incurred** *(canceled checks/credit card statements will not be accepted).* Print or type the information requested, then sign and date the form – if the form is not signed, your claim will be returned to you for a signature. You may fax, email or mail this form along with your supporting documentation to bswift. **To check your account balance online, print forms, or access a list of eligible expenses, please visit: www.hrbenefitsdirect.com/bswift**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT EXPENSES

****** Remember to submit a Medical Necessity Form for over-the-counter medicines due to IRS guideline changes effective January 1, 2011!******

DATE OF SERVICE *(Date services were incurred)*	DESCRIPTION OF EXPENSE *(Prescription, Office Visit, Dental)*	NAME & RELATIONSHIP OF PERSON WHO INCURRED EXPENSE *(Example: Bob Jones – Spouse)*	PROVIDER OF SERVICE *(Pharmacy, Dr. Smith, etc.)*	* IS EXPENSE COVERED BY ANY OTHER PLAN?	AMOUNT OF EXPENSE REQUESTED
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
**** If the expense is covered by an insurance plan, please submit the insurance EOB with this form.***				**TOTAL EXPENSES:**	**$**

If you are submitting a claim for expenses incurred by a dependent and we need further information in order to process the claim, your dependent is deemed to authorize you to respond to our request.

To the best of my knowledge and belief, my statements on this Request for Reimbursement Form are complete and true. I certify that my dependent or I have received the services described above on the dates indicated. If I am enrolled in a post-deductible/limited-purpose FSA, I further certify that the expenses are qualified under the Plan, meaning that the expenses are for uninsured dental care, uninsured vision care, uninsured preventive care or uninsured expenses in excess of the minimum annual deductible under a qualified high deductible health plan and I am providing, along with this claim form, substantiation from an independent third party that the expense are qualified. If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent in the Plan. I certify that I have not been reimbursed previously for these expenses under the health care FSA. I certify that these expenses have not been reimbursed by, and I will not seek reimbursement for these expenses from, any medical plan, insurance plan, health care FSA or other source. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes. If the reimbursement request is for an over-the-counter drug, I certify that the drug was prescribed by a physician or is insulin. I understand that these expenses may not be used to claim any federal income tax deduction. I authorize a deduction in my health care FSA in the amount of the reimbursement.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT EXPENSES

DATES OF SERVICE *('From – Through' Dates the Care was Provided)*	DEPENDENT'S NAME & RELATIONSHIP	** DEPENDENT CARE PROVIDER'S SIGNATURE *(Only if no receipt from the provider is attached)*	AMOUNT OF EXPENSE REQUESTED
***** Form must include dep. care provider's signature above if you are not supplying a receipt with this form.***		**TOTAL EXPENSES:**	**$**

For information as to what dependent care expenses can be reimbursed, see the summary plan description and IRS Publication 503. Note: To be reimbursed, you must provide the dependent care provider's SIGNATURE *(OR a receipt from the provider)* .

To the best of my knowledge and belief, my statements on this Request for Reimbursement Form are complete and true. I have read, understand and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Form. I understand that these dependent care expenses may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit). I certify that I have obtained the taxpayer identification number (in the case of an entity) or Social Security number (in the case of an individual) who provides the above described care for inclusion on IRS Form 2441 which will be filed with my annual federal income tax return. I authorize a reduction in my dependent care FSA in the amount of the reimbursement.

EMPLOYEE SIGNATURE:		**DATE:**	

The fact that complete and proper claims for benefits made by individuals covered by the Program will be promptly processed, but that in the event there are delays in processing claims, the individuals covered by the Program shall have no greater rights to interest or other remedies against TPA than as otherwise afforded them by law.

bswift 5001 Plainfield Ave NE, Ste A; Grand Rapids, MI 49525 • **Ph** (616) or (866) 365-2413 • **Fx** (616) 301-1873 or (888) 856-7852 • FSAdept@bswift.com

ADDITIONAL INSTRUCTIONS FOR FSA CLAIMS

1. Only employees participating in the plan can submit a reimbursement form.
2. **Current employees** may submit claims for up to **a specific number of days** after the plan year-end for expenses incurred during the prior plan year or applicable grace period. Please consult your benefits dept or bswift for this information.
3. **Terminated employees** may be reimbursed for expenses incurred through the last day of participation (termination date). Claims must be submitted within **a specific number of days** after the date termination occurred. Please consult your benefits dept or bswift for this information.
4. Reimbursements may only be made for eligible expenses **incurred during the plan year or applicable grace period**.
5. IRS rules stipulate that any money left in your account(s) after all reimbursements for the Plan Year have been processed may not be carried forward or returned. Money left in the health care spending account may not be used to reimburse dependent care expenses, and vice versa.
6. If you receive reimbursement for expenses, you may **not** claim these expenses as a deduction for income tax purposes.
7. Complete the information on the reimbursement request form for each amount claimed for reimbursement.
8. Attach an **itemized** receipt or bill showing the date of service, amount of charge, patient name, name and address of provider and a complete description of the expense. Make a photocopy of the documentation and the reimbursement form for your records. If you have medical/Rx, dental, vision coverage for the expenses, please attach copies of **Explanation of Benefits (EOBs)** from your insurance carrier(s).
9. Submit your reimbursement form to bswift. A blank Request for Reimbursement Form will be sent with your reimbursement check. Additional forms are available from your Employer's Human Resources Department or via web at: www.hrbenefitsdirect.com/bswift

ELIGIBLE HEALTH CARE EXPENSES

Following is a list of the more common eligible expenses. A comprehensive list is available online under **Health Care Expense Table.** Some expenses may require a medical necessity form from the treating physician. For more information, please contact your bswift representative directly.

- Acupuncture
- Bandages
- Blood-pressure Monitoring Devices
- Blood-sugar Test Kits and Test Strips
- Braces and Supports
- Catheters
- Chiropractic Care
- Contact Lenses (corrective lenses - not cosmetic),Supplies and Solution
- Co-pays and Co-insurance Amounts
- Deductibles
- Dental Cleanings, X-rays, Fillings, Braces, Extractions
- Diabetic Supplies
- Eye Exams, Eyeglasses (corrective lenses), Equipment and Materials (excluding clip-on sunglasses/non-Rx sunglasses)
- First Aid Supplies
- Flu Shots
- Hearing Aids
- Immunizations
- Incontinence Supplies
- Insulin
- Laboratory Fees
- Laser Eye Surgery/Lasik
- Mileage for Person to Receive Medical Care
- Obstetrical Expenses
- Occlusal Guards to Prevent Teeth Grinding
- Orthodontia
- Physical Exams
- Physical Therapy
- Pregnancy Tests
- Prescribed Contraceptives
- Prescription Drugs/Medicines
- Psychiatric Care
- Reading Glasses
- Smoking Cessation Programs
- Therapy (medically-related only - *not* marriage counseling, general mental health wellness, relief of stress)
- Walkers, Wheelchairs, Canes

INELIGIBLE HEALTH CARE EXPENSES

Following are examples of *some* expenses that are not eligible under the HCFSA plan. This is not a complete list. If you have specific questions, please contact your bswift representative directly.

- Amounts paid by a health insurance plan or any other plan (FSA, HRA, HSA)
- COBRA Premiums
- Cosmetic Procedures
- Diet Foods
- Expenses You Claim on Your Federal Income Tax Return
- Expenses Incurred Before you began Participating in the FSA
- Face Creams
- Feminine Hygiene Products (Tampons, etc.)
- Funeral Expenses
- Hair Removal/Transplants
- Illegal Operations and Treatments
- Insurance Premiums
- Late Fees/Missed Appointment Fees
- Makeup/Nail Polish
- Marijuana or Other Controlled Substances in Violation of Federal Law
- Maternity Clothes
- Mouthwash/Dental Floss/Toothbrush/Toothpaste
- Nursing Services for Health Baby
- One-A-Day Vitamins
- Over-the-counter Drugs Unless Prescribed by a Physician or the Drug is Insulin
- Prepayments for Services
- Safety Glasses (non-prescription)
- Shampoo/Soap/Moisturizers/Deodorant
- Shaving Cream/Lotion
- Tanning Salons/Equipment
- Teeth Whitening
- Vision Discount Program/Service Agreements/Warranties

DEPENDENT CARE FSA REQUIREMENTS

By signing and submitting the Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet *all* of the following conditions:

1. The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year to which the election applies.
2. The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of self-care.
3. The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of (A) your earned income; or (B) if you are married, your spouse's actual or deemed earned income.
   Please refer to IRS Publication 503 to determine the earned income amount for your spouse.
4. Each dependent for whom you incur the expenses is (A) a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return, or (B) your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
5. You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(A) or 4(B) above.
6. The expenses are incurred for the care of a dependent, or for related incidental household services.
7. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(A) above
   (or who is described in 4(B) above and regularly spends at least eight hours per day in your household).
8. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
9. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
10. The expenses are not paid for services outside your household at a camp where the dependent stays overnight.