Flexible Spending Account Claim Form

Send To: Midwest Group Benefits, Inc., PO Box 408, Decorah IA 52101
Phone: 563/382-9611 **Fax:** 563/382-9613

Please complete all information requested. See the back of this form for further instructions.

You can fill this form out on-line, print and sign OR print the form and fill it out by hand.

Employee Information

Employer _____ Employee Name _____ Social Security Number _____

Employee Address _____ [ ] Yes [ ] No Is this a new address?

Health Claims

When filing for expenses eligible under your insurance, but not paid (deductibles, co-insurance, etc.) be sure to **attach copies of the Explanation of Benefits** from your insurance company, showing the extent of reimbursement or denial of claims. For expenses that are not eligible under your insurance, **attach an itemized bill that includes the information requested below.** ***Cancelled checks and bills showing "Balance Forward" or "Previous Balance" are not acceptable.***

Patient Name	Relation to Employee	Description of Service	Provider of Service	Service Date	Amount Incurred
				__/__/___	
				__/__/___	
				__/__/___	
				__/__/___	
				__/__/___	
				__/__/___	
				TOTAL:	**0.00**

Dependent / Child Care Claims

If your provider completes and signs the following, no other receipt is required. Otherwise, **a receipt that includes the following information must be attached. Cancelled checks are not acceptable proof of an incurred expense.** Effective January 1, 1989, the IRS requires the dependent / child care provider(s) to furnish the provider's current name, address and tax identification number (or social security number) to the taxpayer making claim, unless the provider is exempt from federal income taxation as described in IRC Section 501(c)(3). A provider failing to comply with this law is subject to a $50 fine for each such failure unless proven that failure is due to reasonable cause, not willful neglect. The dependent care information including provider(s) name, address, TIN/SSN is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.

Name of Dependent	Age	TIN/SSN	Provider Address	Provider Signature	Service Date	Amount Incurred
					__/__/___	
					__/__/___	
					__/__/___	
					__/__/___	
					__/__/___	
					__/__/___	
					TOTAL:	**0.00**

Signature

I request reimbursement from my flexible spending account(s) as listed above and certify that these are legitimate expenses which I or my dependents have incurred. I understand expenses must qualify as deductible expenses for federal income tax purposes and cannot be reimbursed from any other source or used as a deduction on my personal income tax return(s). I fully understand that I alone am responsible for the sufficiency, accuracy and veracity of all information relating to this claim, and unless an expense for which payment or reimbursement is claimed as a proper expense under the Plan, I may be liable for payment of federal, state and city income taxes on amounts paid from the Plan which relate to such expenses.

Participant's Signature _____ Date _____

CLEAR Button

WARNING: When using public computers at a library, school, etc., be sure to click on the "Clear Form" button after completing and printing your form. Even though you log-off or close the Internet site, the next person may be able to access the prior user's data.

Midwest Group Benefits
PO Box 408
Decorah, IA 52101

Reimbursement of Expenses

Contributions made during any Plan Year can be used only for reimbursement of expenses incurred during that Plan Year. Expenses are incurred on the date services are provided.

Expenses reimbursed through these accounts are not eligible for tax deduction or credits.

Health Care Expenses

Eligible health care expenses are those which would normally be deductible for federal income tax purposes (without regard to adjusted gross income limitations). Expenses incurred by you, your spouse or your dependents which are not reimbursed from another source (i.e. insurance) are eligible for reimbursement.

Included are:

- Medical and dental expenses which are covered but not paid by insurance (deductible amounts paid before benefits begin and the percentage of charges not covered).
- Vision and hearing expenses including examinations, eyeglasses, contact lenses, hearing aids and seeing-eye dogs.
- Dental care, including braces.
- Routine physical examinations, x-rays and lab fees.
- Prescription drugs, including insulin and birth control pills.
- Special equipment bought or rented because of a physical problem (wheelchairs, crutches, orthopedic shoes, etc.)
- Ambulance service and other transportation costs necessary to receive medical care.

For more information, see IRS Publication 502, "Medical and Dental Expenses", available from your local IRS Office.

Dependent Care Expenses

Only those dependent care expenses which allow you (and your spouse, if you are married) to be gainfully employed are eligible. This excludes care which is primarily for medical or educational purposes. Dependent care expenses reimbursed through the Plan cannot be applied toward the tax credit. Maximum expenses for the tax credit calculation are reduced by the amount of expenses reimbursed through this Plan.

Eligible Dependents

- Dependent children under age 13 or any other dependent who is incapable of caring for himself or herself and whole principal residence is your home.

Eligible Expenses

- Reimbursement is limited to the income of the lower earning spouse. If your spouse is a full-time student or incapable of caring for himself or herself, the maximum is $200.00 for one child or $400.00 per month for two or more children.

Eligible Providers

- A licensed daycare center.
- An unlicensed provider caring for less than six persons.
- An in-home provider, as long as that person is not your child under age 19 or someone you and your spouse claim as a dependent for tax purposes.

For more information, see IRS Publication 503 "Child and Dependent Care Credit", available from your local IRS Office.