

# DIVERSE – CHOICE *Section 125*

## REIMBURSEMENT REQUEST FORM

### Flexible Spending Reimbursement

**Instructions Are On The Back Of This Form**

<b>Company</b>		<b>Group #</b>
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>
<b>Address</b>		
<b>Identification Number</b>		<b>Work Phone</b>

**From Your Medical Reimbursement Account** (Un-reimbursed Medical Expenses)

Services Provided By	Patient Name(s)	Type of Expense*	Date Incurred	Total Expense	Insurance Paid and PPO Discount	Reimbursement Requested
		See Codes	mm/dd/yy	\$	- \$	= \$
				\$	- \$	= \$
				\$	- \$	= \$
				\$	- \$	= \$
				\$	- \$	= \$

**Add the Reimbursement Requested Column to get the Total Reimbursement Requested = \$**

If your Company has Auto-Up-Date from Claims processing to your Flex Account: Once you or your provider has submitted the claim to your Health Insurance Plan and the claim is completed any eligible expense will automatically pay out to you from your Flex Medical Reimbursement Account. You need do nothing more.

**\*Type of Expenses Codes**  
**M = Fees to Doctors, Nurses, & Labs**                      **A = Dental Care**                      **V = Vision, Eye care**  
**R = Prescription Drugs**                                      **O = Other (Special Equipment, etc.)**

**From Your Dependent Care Account** (Day Care Expenses)

Services Provided By	Taxpayer ID Number	Dependent's Name	Relationship to	Date Incurred from	to	Reimbursement Requested
						\$
						\$
						\$
						\$

**Add the Reimbursement Requested Column to get the Total Reimbursement Requested = \$**

**Participant Certification**  
 I have read and understand the rules for these accounts. I realize that I am responsible for individual income tax impacts and compliance with the Internal Revenue Service. I also understand that reimbursements cannot exceed the annual amounts elected in that account. I certify that I have paid the above expenses for which reimbursement is claimed for myself or my eligible dependents which are legitimate expenses incurred on the dates noted above and are not payable by insurance coverage or any other plan. I further declare that I will not deduct these expenses on my federal income tax returns.

<b>Participant's Signature</b>	<b>Date</b>
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# Rules and Instructions For Reimbursement

## Flexible Spending Reimbursement

### How to Complete The Form

To receive reimbursement you must provide proof of service and if your plan requires proof of payment from a third party provider. As proof of service attach your group insurance "Explanation of Benefits" (EOB), if you do not have any insurance coverage, an itemized bill from the provider is required, along with your proof of payment. For example, as proof of payment submit either: a bill marked paid; Form of Proof of Child/Dependent Care, signed by the provider; a copy of both sides of your canceled check; a credit card receipt, or an account statement showing payment or balances.

If you have coverage through an HMO Plan and are required only to pay an up-front co-pay. We will accept a co-pay receipt as long as the following information is on the receipt: Provider name and address, Patient name, and Date of service.

You must read and then sign the Participant Certification. Then submit your paperwork in an envelope marked attention **Flex Department**, and mail to:

**Diversified Administration Corp., P.O. Box 299, Marlborough, CT 06447,**  
**or you may Fax your submission to: (860) 295-0340, It's your responsibility to maintain original**  
**documentation for use should the IRS request an audit of your account.**

Reimbursements from any one account cannot exceed the amounts for the annual election in that account. Monies cannot be transferred amongst accounts. The IRS "Use it or Lose it" rule states that any unused balances remaining in an account at the end of the Plan Year will be lost ("forfeited") and no longer available to you. Requests for reimbursement must be for services incurred during the Plan Year; it doesn't matter when you paid, just the date of service. Requests must be made within the 90 day run off for the plan year, (March 31<sup>st</sup>).

For inquiries about a claim already submitted or how to submit a claim, contact the Flex Department at Diversified Administration Corporation, during normal business hours at: **(860) 295-0238**, toll free **1 888 322-2524**, or e-mail [eebenereim@diversifiedgb.com](mailto:eebenereim@diversifiedgb.com)

### Examples of Expenses Which May Be Allowed

#### From the Medical Reimbursement Account:

(See IRS rules for Form 1040, Schedule A, lines 1-4 and Publication 502)

Qualified expenses are for out-of-pocket medical care, paid by you, your spouse, or your dependents (any dependent qualifying on your Form 1040) which would normally be deducted on your federal income tax return and is not reimbursed under any other insurance or plan. For example:

- **Deductibles you pay under your group insurance plan(s)**
- **Eye care (such as: routine eye exams, eye glasses contact lenses, and supplies for contact lenses)**
- **Dental care (such as: checkups/exams, dentures, orthodontia, braces, oral surgery)**
- **If not covered, fees to Physicians, Chiropractors, Obstetricians, Hospitals, Pediatricians, Lab fees, Gynecologists, Nurses, etc.**
- **Co-payments (amounts you pay) under group insurance coverage's.**
- **Fees for services provided to Psychologist, Psychiatrists.**
- **Prescription drugs (including insulin, laetrile, and birth control pills)**
- **Special equipment, if qualified (such as: crutches, wheelchairs, seeing eye dogs, hearing aids, car controls, Braille, etc.)**
- **Special treatment, if qualified (such as: alcoholism treatment, halfway house residency, or lifetime care at a medical facility)**

#### From the Dependent Care Account:

(See IRS rules for Form 2441 and Publication 503)

You must provide the taxpayer identification number (ID#) of the provider. For individuals this will be their social security number (SSN); for corporations their employer identification number (EIN); for tax-exempt organizations write in "tax exempt".

Qualified expenses must be employment related, and would normally be deducted on your federal income tax return as fees for day care to an eligible dependent while you are at work (and, if married, your spouse either works, is disabled, or is a full-time student). An eligible dependent is a child under age 13, or can be any age, if not capable of self-care (physically or mentally handicapped), For example:

- **Schooling prior to the first grade**
- **Day care center or other certified day care facility**
- **Before and after school care**
- **Household services only if they provided for the care of the dependent as well as the home (such as: housekeeper, baby-sitter, maid, cook, cleaning person) and only for the period of time you and your spouse are at work..**