

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Mail to: **KCI FINANCIAL SERVICES, INC.**
11011 Sheridan Street Suite 202
Cooper City, FL 33026
Phone: 954-443-4443 Fax: 954-443-4445

Request for Reimbursement

Employer (please type or print): _____

Employee Name: _____ Social Security Number: _____

Employee Address: _____

Please check if new address: City _____ State _____ Zip _____

Dependent/Child Care LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary)

A	B	C	D	KCI Use Only		
Name of Dependent	Age	Provider Name	Provider ID#	Date of Service	Requested Amount of Reimbursement	KCI Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

Provider's Certification/Verification

I certify that the above described Dependent Care expenses were incurred by the employee named above.

Business/Provider Signature _____ Address _____ Date _____

Unreimbursed Medical LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary)

A	B	C	D	E	KCI Use Only	
Patient Name	Age	Provider Name	Description of Service	Date of Service	Requested Amount of Reimbursement	KCI Use Only

Please attach a third-party receipt, itemized bill or explanation of benefits (EOB) listing (A), (B), (C), (D) and (E) or have a provider certify below. Cancelled checks, credit card receipts or bills showing a previous balance or balance due only are not acceptable.

Provider's Certification/Verification

I certify that the above described Unreimbursed Medical expenses were incurred by the employee named above.

Business/Provider Signature _____ Address _____ Date _____

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Care Expenses that I or my dependents have incurred. I understand that medical expenses must qualify as deductible expenses for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Care Expenses must qualify for the dependent care tax credit and I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Date: _____

Employee Signature: _____

See reverse side/next page for instructions

HOW TO FILE A REQUEST FOR REIMBURSEMENT:

1. Complete the entire claim form, being sure to sign and date it. Failure to complete all areas can result in a delay in the processing and claim reimbursement.
2. Attach itemized bills, receipts or Explanation of Benefits (EOB's) which show:
 - Name of person receiving service.
 - Nature of service or supplies furnished and charges for each of them.
 - Date(s) of service.
 - Name of provider(s), address and tax identification number (Federal ID number or Social Security number).
3. The business/provider may sign this form in lieu of attaching a receipt.
4. If you carry group insurance, first submit expenses to the insurance carrier. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible.
5. Checks are **not** written for less than \$15.00
6. Receipts for over-the-counter (OTC) medicines and drugs must be clearly marked with the name of the item circled or highlighted, and the medical condition for which the purchase was made. Only reasonable quantities of OTC medicines and drugs are reimbursable. Reasonable quantities are defined as amounts of OTC medicines and drugs which can "reasonably" be expected to be used during the Plan Year. OTC medicines and drugs must meet the definition of "medical care" under Code Section 213(d) and Treas. Reg. 1.213-1(e). Certain OTC medicines and drugs that are considered "dual-purpose" (ones that may have both a medical purpose and a personal/cosmetic or general health purpose) may require a note from a medical practitioner stating that the person has a specific medical condition and that the OTC drug is recommended to treat it and that the treatment is not a cosmetic procedure.
7. Vitamins and supplements are **not** eligible for reimbursement.
8. OTC medicines and drugs for strictly cosmetic purposes are **not** eligible for reimbursement.

QUALIFYING EXPENSES

To qualify for reimbursement, expenses must be incurred during the plan year for which you are requesting reimbursement.

1. Unreimbursed Medical Account – can be used for medical expenses for you or your family which are not covered by any other health plan. Items covered include, but are not limited to:
 - Deductibles/coinsurance.
 - Medical, dental and vision services.
 - Hearing exams.
2. Dependent/Child Care Account – reimburses for care of your child or other tax dependents while you are at work. For services at a dependent care center, the center must comply with all state and local laws. Specifications for this account are:
 - Your child must be age 12 or under.
 - Your child or other dependents over the age of 13 must be incapable of self-support and spend 8 hours or more a day in your home.
 - The individual caring for your child age 12 and under or other dependent must not be a tax dependent.
 - Reimbursement cannot exceed \$5,000 annually (\$2,500 if married filing separate tax returns) or the earned income of you or your spouse, whichever ever is less.
 - I understand that the taxpayer identification number (Social Security) of any dependent care service provider must be supplied to the IRS on my annual tax return (Form 2441).

LIMITATIONS

The following are maximum **per occurrence limitations** for reimbursement for Medical Expenses:

In-Patient Hospitalization	\$200.00
Out Patient Services	\$100.00
Surgical	\$200.00
Major Orthodontic Services	\$100.00
Doctor/Dental Services	\$100.00
Chiropractor Visits	\$ 50.00
Eyeglasses and Contacts	\$150.00
Medicines and Drugs	\$ 50.00 (Over-the-counter medicines, drugs and medical supplies - <u>excluding</u> vitamins)
Prescription Medication	No Limitation