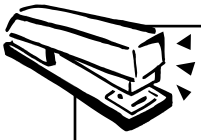

Please attach supporting documentation behind this Request Form.

Reimbursement Request for

★ _____

Enter your employer's name

★= Required Fields

★Employee Name: ★Social Security No.:

Address: Daytime Phone:

☐ Address Change Requested E-Mail Address: _____ Check here if this is a new E-Mail ☐

UNREIMBURSED MEDICAL EXPENSE CLAIMS

(Do Not Complete Shaded Area)

	Date of Service	Name of Service Provider	Name & Relationship of Patient	Amount Requested for Reimbursement	Account Breakdown
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

DEPENDENT CARE CLAIMS

(For Qualifying Child or Dependent Care Expenses – i.e. Daycare)

	Date Range of Period Covered From: To:	Daycare Provider Name & Taxpayer ID Number	Name & Date of Birth of Dependent	Amount Incurred
1.				
2.				
3.				
4.				
5.				

_____

Daycare Care Provider's Signature *Date* *Total Amount*

READ CAREFULLY

I certify that the expenses listed above are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code. I also understand that reimbursement expenses cannot also be claimed as credits or deductions on my personal tax return.

★ _____

Employee's Signature *Date*

PLEASE NOTE:

- Most employers have a minimum reimbursement amount of $40.00.
- Cancelled checks are insufficient for claim substantiation according to IRS guidelines.
- Claims with incomplete information or without proper attachments will be returned to you.
- You will have a run-off period after the Plan year ends to submit expenses incurred during the Plan year. Consult your Human Resources Department. Any monies remaining in your health or dependent care account will be forfeited.
- Keep a copy of all expenses claimed for your records. The validity of expenses is your responsibility in the event of an audit by the IRS.

csONE BENEFIT SOLUTIONS
FLEXIBLE BENEFITS REIMBURSEMENT ACCOUNTS
INSTRUCTIONS AND GUIDELINES

Please complete all sections:

1. Employee Information

2. Unreimbursed Medical Expense Claims and/or Dependent Care Expense Claims.

3. Certification Statement

Please attach appropriate documents:

1. Services Covered by an Insurance Plan:
Attach explanation of benefits (EOB) report, from your Health Insurance Provider, as proof of non-reimbursement.

2. Services Not Covered by an Insurance Plan:
Attach a receipt from the service provider which includes:

- Date of Service
- Name of Service Provider
- Name of Patient
- Service Provided
- Amount Requested for Reimbursement

3. Dependent Care Claims:
Attach a receipt from the daycare provider which includes:

- Date Range of Period Covered
- Daycare Provider Information
- Dependent Name and Date of Birth
- Amount Incurred
- Signature of Daycare Provider or Detailed Invoice from Provider

Note: Eligible Medical Expense Claims are qualified medical/dental expenses of the employee, spouse and dependent(s) that are not eligible for reimbursement from any other source.

Deliver/ Mail/ Fax/ E-mail this completed form with attachments to:

Flexible Benefits Department – csONE Benefit Solutions

Mailing Address: PO Box 1320, Concord, NH 03302-1320

Phone: 1 888 227-9745 ext. 2040 **FAX:** 1 603 224-4256

E-Mail: flexiblebenefits@csONE.com

Located at: Two Delta Drive, Suite 301, Concord, New Hampshire

If you apply for reimbursement of expenses that the IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement of expenses that have already been reimbursed from some other source.