Request for Reimbursement

Healthcare FSA, Limited FSA, Dependent Day Care

Submit by Email
mybenefits@ebs-tpa.com

Submit by Fax
Fax: 888-511-3743

Name:	**Social Security Number or EE ID number:**
Home Address:	**Employer:**
City: **State:** **Zip:**	**Daytime phone:**
☐ Check here if this is a new address	**Email Address:**

Flexible Spending Account Reimbursement – Fill in required information and attach an itemized bill, Explanation of Benefits (EOB), or other verification of each expense, indicating; 1. Person receiving care, 2. Date(s) of service, 3. Description of service, 4. Health care provider, and 5. Amount requested**. Credit card receipts, cancelled checks, balance forward statements are not eligible forms of documentation.**

Person Receiving Care	Date(s) of Service	Description of Service (Office Visit, Crown, RX)	Health Care Provider (Name of Doctor, Clinic, Hospital)	Amount Requested	EBS Benefit Card used for this expense
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

Dependent Care Reimbursement- Fill in required information and attach an itemized statement, receipt, or other verification indicating; 1. Dependent full name, 2. Dates of care, 3. Provider name, 4. Amount paid, and 5. Provider's signature, **or simply have your provider sign below to certify the care was provided.**

Dependent Receiving Care	Dates of Care (No future dates)	Day Care Provider	Amount Requested

I certify that I provided dependent care services as shown above and are valid expenses.
Signature of Dependent Care Provider: _____ **Date:** _____

Employee Certification: I request reimbursement from my Employee Reimbursement Account(s) for the expenses itemized above. I certify that the expenses for which reimbursement is requested under the reimbursement account(s) were for services received either by me or my eligible dependent(s). I also certify that I or my eligible dependent(s) have received the services described on the dates indicated, and these are my out-of-pocket expenses that qualify as valid expenses under the plan and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan covering health benefits. I also certify that these expenses are to alleviate a medical condition and not just merely beneficial to my general health. I understand that if I, my spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a Limited Purpose Medical Reimbursement Account which can only pay qualifying expenses related to vision and dental care. I further understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. To the best of my knowledge and belief, my statements on this form are complete and true.

Employee Signature: (REQUIRED) _____ **Date:** _____

GUIDELINES FOR ELIGIBLE REIMBURSMENT

General Guidelines

Employee Reimbursement Accounts are a part of Section 125 of the Internal Revenue Code that governs the tax status of Flexible Benefit Plans. Eligibility for pre-tax reimbursement is covered in Code Sections 105 /106 (Accident/Health Plans) and Section 129 (Dependent Care).

- Reimbursement will be made directly to you; you are responsible for paying your provider.
- According to the Internal Revenue Code, 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.
- Ineligible expenses include overpayments of reimbursable expenses, expenses that have already been paid from other sources, expenses not eligible for reimbursement as defined in Section 213(d) of the IRS Code, or as described by the plan.
- Cafeteria plans may only reimburse expenses incurred within the plan year. An expense is incurred when the service the is provided, not when the expense is paid.
- For specific detail on claim filing, reimbursement, and review procedures, please reference your Summary Plan Description.
- Eligible expenses and services are detailed on the EBS website at www.ebs-tpa.com

General Purpose Flex Spending Account (FSA)

Eligible expenses are qualified medical, dental and vision expenses not eligible for reimbursement from any other source.

- You may be reimbursed for expenses for yourself, your spouse, and dependents, as defined in the Internal Revenue Code
- Expenses that can be reimbursed under your health insurance plan should not be included on this form
- Expenses for services which are not medically necessary (i.e. cosmetic) should not be included on this form

Limited Purpose Flex Spending Account (LFSA)

- Eligible to participate if you or your spouse contribute to a Health Savings Account (HSA)
- Expenses limited to qualifying vision and dental expenses

Dependent Care Reimbursement (DCA)

- Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include your qualifying child under age 13, your disabled spouse or disabled qualifying child who lives with you for more than half the year, and a disabled qualifying relative who lives with you for more than half the year, for whom you provide over half his or her support.
- To be eligible, you must be working while your dependents receive care. If you are married, your spouse must be a wage earner or a full-time student for at least 5 months during the year, or is disabled and unable to provide for his or her own care.
- Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed. Covered expenses include licensed day care centers or individuals other than your dependents who provide care for your children in or outside your home.
- You will be required to provide the name, address, and social security (or other tax I.D.) number of your day care provider on your federal income tax forms at year end.
- Reimbursements are available as payroll contributions have posted to your account. If claims submitted are greater than the balance in your dependent care account, reimbursement will be limited to your account balance. The un-reimbursed amount will carry forward to subsequent months in the plan year; you need not resubmit.
- IRS Regulation limits the amount you can contribute to the dependent care account to $5000 for a single parent with children, $5000 for a married parent filing jointly, and $2,500 for a married parent filing separately.
- Under IRS Regulations, qualified individuals can receive a tax credit for dependent care costs. This credit can be claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by the amount you use from the Dependent Care Reimbursement Account.