



P.O. Box 247
Onalaska, WI 54650

Phone: 779-3000 or 888-540-0094
Fax: 779-3009 or 877-540-0094

Request for Reimbursement from Medical and Dependent Care Flexible Spending Account

Participant's Name: _____

Employer's Name: _____

Medical Reimbursement Expenses

Date of Service	Name of Patient	Expense Description	Name of Service Provider	Amount Incurred
TOTAL				

Dependent Care Reimbursement (Day Care Expenses)

Dates of Coverage		Name of Dependent(s)	Provider of Service	Amount Paid
From	To			
			Name:	
			Address:	
			Tax ID or SSN:	
TOTAL	*Attach detailed receipt or you may include the provider's signature instead. Provider Signature:			

This is to certify that my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Compensation Account to be reduced by the amount requested.

Participant's Signature

Date

Flexible Spending Reimbursement Rules and Claim Filing Instructions

Medical Reimbursement

The IRS requires that a fully completed claim form be submitted with every claim. When submitting the claim form, please make sure the form is signed, dated, and the amounts being requested are itemized on the claim form. Please keep a copy of the completed claim form for your records.

The IRS also requires that the supporting documentation include the following information: the date service was incurred, the type of service, the provider's name, the patient's name, and the amount of the service less any insurance payments. The most common source of this information is the Explanation of Benefits (EOB) from the insurance carrier or the prescription receipt from your pharmacist.

Please note that the IRS guidelines do not accept statements that indicate a "Balance Forward" or "Previous Balance", cancelled check copies, cash register receipts, or credit card receipts as proof of service. Most of these statements do not include the required information.

You may be reimbursed for eligible expenses incurred during the coverage period in which your contributions are made. The date of service must be during the current plan year. Expenses must be incurred prior to reimbursement.

If you terminate employment you can submit a claim for a specific period after the date of termination if so stated in the Summary Plan Document as long as the service occurred before your date of termination.

IRS rules stipulate that any money left in your account after all reimbursements for the plan year have been processed will be forfeited. Money cannot transfer between accounts, nor can any reimbursed expense be claimed as a deduction or credit for income tax purposes.

Submit this form with attached supporting documentation to 3PAdministrators according to the procedures provided. Additional Request for Reimbursement forms are available from your employer or 3PAdministrators.

Dependent Care Reimbursement

You can use a Dependent Care Spending Account only if you pay dependent daycare expenses to be able to work. Your daycare services can take place either inside or outside of your home. If you are married, your spouse must also work, go to school full time or be incapable of self care.

Only a dependent under the age of 13, or dependent adults 13 or older who are mentally or physically incapable of self care are eligible.

Your maximum contribution amount cannot be more than the smaller of: (a) Your income or your spouse's income, whichever is smaller. If your spouse is a full time student or incapable of self care, your spouse is considered to earn \$2400 per year with one dependent or \$4800 with two or more dependents. (b) \$5000 per year if your tax filing status is "married filing jointly" or "single head of household" or \$2500 per year if your filing status is "married filing separately".

You cannot claim expenses if the service provider is your child or stepchild under age 19, or if you claim the service provider as a dependent for Federal income tax purposes.

To be reimbursed, you must include the facility's name, address and tax identification number, or social security number of the individual providing the dependent daycare service. Daycare expenses must be incurred prior to reimbursement.

You will only be reimbursed the amount that you have contributed to your account. Claims filed that are over the amount you have contributed will be pended and paid during the next contribution period.

Please allow at least 5 business days for processing claims. Your check will be mailed to your current home address on file. You may submit your claims by mail to 3PAdministrators, P.O. Box 247, Onalaska, WI 54650, by fax to 877-540-0094, by e-mail at info@3pa.com or online. Please call 779-3000 or 888 540-0094 with any questions.