



2007 FLEXIBLE SPENDING ACCOUNTS CLAIM FORM

Employee Name: _____ Social Security #: _____

Department: _____ Phone: _____

Use a separate claim form for each account. Place an "X" in appropriate box to indicate the account from which you are requesting reimbursement.

Health Care Spending Account

Dependent Care Spending Account

INSTRUCTIONS:

To qualify for reimbursement the following is required:

1. The expense must be incurred by you or one of your dependents who is claimed as a dependent on your federal income tax return.
2. Minimum request amount is \$100.00 (Keep receipts for smaller amounts until they reach or exceed the \$100.00 amount.) Your final calendar-year claim may be less than \$100.00.
3. If there is a health care question as to the eligibility of particular expenses or the dependency status of a particular individual, more information may be requested.
4. ALL MEDICAL, DENTAL, AND OPTICAL CLAIMS MUST FIRST BE PROCESSED THROUGH YOUR MEDICAL/ DENTAL PLANS BEFORE SUBMITTING TO YOUR HEALTH CARE REIMBURSEMENT ACCOUNT.
5. **YOU MUST** attach all the pages of the **original "EXPLANATION OF BENEFITS"** (EOB) from your medical, dental or optical plan to this form and forward it to the Benefits Office. Failure to do so will prevent further processing and your claim will be returned to you.

REIMBURSEMENT INFORMATION (See Eligibility Information on Reverse Side)

Provider of Service	Service Date Month/Day/Year	Amount for which you are requesting reimbursement
1.		
2.		
3.		
4.		
5.		
Total Reimbursement Request Amount (Minimum \$100):		\$

YOUR SIGNATURE:

I request reimbursement for the expenses itemized above.

I certify that I have not requested reimbursement under this plan or from any other source for the above expenses. I also certify that any medical expenses I submit have not been reimbursed or are not reimbursable under any other health coverage. I also certify that the total Dependent Care expenses for which I am requesting reimbursement for this plan year do not exceed the lesser of my or my spouse's expected income for the year. I further certify that the Health Care and Dependent Care expenses meet all the requirements listed on the back of this form.

Employee Signature: _____ Date: _____

Reimbursement Information

HEALTH CARE EXPENSES

1. You may be reimbursed for certain health care expenses which would otherwise be a deductible item on your Federal income tax return.
2. You may receive up to the amount you have agreed to contribute for the current year by supplying the necessary documentation verifying the claim. This documentation should be the Explanation of Benefits from an insurance company describing the outstanding balance being claimed. If you do not have insurance, and only then, a detailed bill or receipt can be used.
3. Expenses covered by other available medical plan, should be filed as a Medical Plan claim prior to being submitted as a Spending Account claim.
4. The expense being claimed may not be reimbursed from any other sources or deducted on your personal income tax.
5. Examples of eligible expenses are: medical plan deductibles and copayments, amounts over usual and customary allowance, vision care expenses, dental care expenses and orthodontic, routine physicals, hearing exams and hearing aids, vision exams and glasses, eligible over the counter expenses, travel expenses primarily for and essential to health care and health care associated with adoption. All such expenses must have been incurred during the plan year claimed.
6. Payments for orthodontic services may be submitted monthly after payment is made to the provider. Use the date of payment for the "Service Date." Please submit receipt or Explanation of Benefits (EOB) showing what your insurance paid the provider.

Reimbursement will be half of the amount charged, until employee's \$1,500 insurance maximum has been reached. If the maximum (\$1,500) coverage has been reached, please attach the EOB indicating this.

7. All other health care expenses which have not been processed under the provisions of the BCBS Medical Plan should be supported by bills which state:
 - provider of service (name and address)
 - person receiving service
 - type of service or supply
 - amount of charge for service or supply
 - date of service
8. If your claim includes travel expenses associated with health care, record your computation of mileage for your records. Travel mileage to obtain health care must meet IRS regulations. You may deduct out-of-pocket expenses for your car as specified by the IRS or use the IRS annual standard mileage rate. Add parking and tolls to the amount you claim under either method.

Please provide proof of the appointment you are traveling to, such as, a receipt from the doctor, hospital, or the BCBS EOB.

Refer to IRS Publication 502 for detailed information on eligible health care expenses. Services must, however, be incurred in the year claimed.

DEPENDENT CARE EXPENSES

Any dependent care expenses you claim must be for the care of a dependent under age 13, disabled dependent or a disabled spouse - so that you (and your spouse, if you are married) can work. In order to be reimbursed, the expenses must meet the following requirements:

1. The expenses must be for a qualifying person; a dependent under age 13 for whom you claim a dependency exemption for tax purposes, or a spouse or dependent who is physically or mentally not able to care for himself or herself.
2. The expenses must be for the well-being and protection of a qualifying person so that you (and your spouse, if you are married) can work. Expenses for services necessary to run your home by a housekeeper or maid are covered if they are partly for the well-being and protection of a qualifying person. Expenses for food, clothing, education or entertainment for a qualifying person are not covered.
3. If care is provided outside your home for a disabled spouse or dependent, he/she must spend at least eight hours each day in your home.
4. If care is provided for your child under age 13 in a day care facility that provides care for seven or more individuals and receives a fee - that facility must comply with all state and local regulations.
5. The care provider cannot be your dependent for tax purposes, or your child, if your child is under 19. The care provider can be a relative who is not your dependent, even if he/she lives in your home.
6. If you are married, your spouse must work or be a full-time student. Also, the total amount of reimbursement for the plan year cannot exceed the income of the lower-paid spouse.
7. The expenses reimbursed under this plan cannot be claimed as a tax credit on your tax return. Any amount not reimbursed can be applied toward the tax credit.
8. Documentation from the dependent care provider must accompany the claim form. A copy of the paid bill or a receipt from the dependent care provider are examples of the required documentation.

Refer to IRS Publication 503 for detailed information on eligible dependent care expenses. Services must, however, be incurred in the year claimed

You have three months after the end of the calendar year to submit any claims. If you terminate your employment during the calendar year, you will have three months after the termination of your health benefits to submit any claims. When submitting claims for either the Health Care Spending Account or the Dependent Care Spending Account, third party documentation verifying that the expenses have been incurred must accompany the claim form.

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