125 PLAN REIMBURSEMENT REQUEST

Check One: ☐ **VERIFICATION OF DEBIT CARD TRANSACTIONS**
☐ **REIMBURSEMENT REQUEST FOR NON-DEBIT CARD EXPENSE**
Important: If no box is checked this will be considered a verification and no reimbursement will be issued.

Last Name, First Name, MI (Please Print) ____________________ Social Security Number ____________________

Street Address ____________________ City, State, Zip ____________________

Employer ____________________ ☐ Check If This Is An Address or Name Change

Email Address ____________________ Telephone ____________________

Dependent Care Assistance (day care, babysitting, etc.)

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period	Admin use only
		From	To *			
		Total Dependent Care Amount Requested →				

I provided the dependent care as stated above. ____________________ ________ ________
Care Provider's **original** signature Date SS#/Tax ID#

Unreimbursed Medical Benefits

Date Medical Care **Provided** *	Name of Medical Provider	General Medical Expense Description	Name and relationship of Person for Whom Expense Incurred	Amount that is your responsibility	Admin use only
	Total Medical Amount Requested →				

Non-Employer Sponsored Premium Account

Period of Coverage *	Name of Insurance Carrier	Describe Expense (Health/Accident)	Person(s) Covered	Net Amount	Admin use only
	Total Premium Amount Requested →				

Employer Sponsored Premium Account

Period of Coverage*	Name of Insurance Carrier	Describe Expense (Health/Accident, etc.)	Person(s) Covered	Net Amount	Admin use only	
	Total Premium Amount Requested →					

* **Reimbursement Requests for future services cannot be accepted**. Please arrange documentation in order listed above**.**

***Policies should be pre-approved by Employer to guarantee their eligibility under Plan provisions.**

NOTE: Federal law requires that you submit a written statement such as the premium statement from the insurance provider. The premium statement should reflect the period of coverage, the premium amount and verification that the premium was not paid to the spouse's employer. Also, you will not be entitled to claim this expense as a tax deduction.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the employer's Cafeteria Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this request which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no tax deduction is permitted for amounts for which reimbursement is made.

____ __________________________

Employee's Signature Date

SEND THIS FORM ALONG WITH SUPPORTING DOCUMENTATION BY MAIL OR FAX TO:

MAIL: **FirstChoice Administrators ● P O Box 10704 ● Springfield, MO 65808**

PHONE: **(417) 890-8988 ● (877) 417-8988**

FAX: **(417) 890-8997 ● (877) 258-0003**

FSA VrfyReimb 7/07

Verification / Reimbursement Request Filing Requirements

1. ***Check the box to indicate if this form is to verify a debit card transaction or is requesting reimbursement for an expense you paid without the debit card.***

2. ***Print your name, address, social security number and name of your employer.***
"X" the Address or Name Change box to indicate a name or address change.

3. ***List expenses by date & arrange the supporting statements in the same order.*** Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
   - Day care requests - complete the Dependent Care Assistance section
   - Health care requests - complete the Flexible Medical Benefits section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

4. ***Enclose required documentation*[*]*.*** A written statement from the dependent care, premium or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing:
   - The name of the dependent care or medical service provider,
   - The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been completed.
   - A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),
   - The name of the person or persons receiving the medical or dependent care, and
   - The cost of the service, not just the amount paid.

   [*]**Dependent Care requests only. -** You may either provide documentation from the day care provider or have the provider complete the Dependent Care Assistance Section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

   Requests filed without the above documentation cannot be processed and will be returned.

5. ***Sign and date*** the request form.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file reimbursement requests for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.