FLEXIBLE SPENDING ACCOUNT CLAIM FORM

► Please do not staple your receipts to this page.

MidAmerica
Administrative & Retirement Solutions, Inc.

Section 1 *This section must be completed fully for all claims.*

Please print

Employer Name: _____

Employee Name: _____ Employee ID: _____ - _____ - _____

Address: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Daytime Phone Number: (____) _____ - _____

☐ Check here if new address

Section 2 *This section must be completed for all claims incurred by you, your spouse, or other eligible dependents.* Supporting documentation must be attached.

Benefit Type Codes:
10 Day Care
20 Medical
21 Pharmacy
22 Vision
23 Dental
24 Misc Medical
25 Over-the-Counter

EXAMPLE:

Benefit Type	Description	Service Dates (MM / DD / YYYY)	Amount Requested
20	*Health Care Expenses*	07/22/2006 – 08/04/2006	$6,653.29

Please use another form for claims in excess of 5 line items.

EXPENSES: (We accept itemized claims only.)

	Benefit Type	Description	Service Dates (MM / DD / YYYY)	Amount Requested
1.			/ / 20 – / / 20	$, .
2.			/ / 20 – / / 20	$, .
3.			/ / 20 – / / 20	$, .
4.			/ / 20 – / / 20	$, .
5.			/ / 20 – / / 20	$, .

Total Amount Requested: $, .

☐ ***If the amount of my claim exceeds the available balance of my medical expenses submitted, please pay any unreimbursed amount from my HRA account.***

Day Care / Dependent Care Provider and Dependent Information:

_____ Dependent's Name Age _____ Dependent's Name Age _____ Dependent's Name Age

If bills or receipts are not available, your service provider must complete the following:

_____ Provider's Signature & Tax ID _____ Date

Section 3 *Employee's Signature is required to process this claim.*

I request payment from the reimbursement account for the expenses itemized above. To the best of my knowledge, my statements on the form are true and complete. These services have been received by qualified individuals of the plan, and I have not (and will not) request reimbursement for these expenses under this plan or from any other source. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.

Employee Signature: _____ Date: _____

We want to promptly process your claim. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Please keep a copy of this claim for your records. Return to: MidAmerica Administrative & Retirement Solutions, Inc., DEPT: 125 ADMIN, 211 E. Main St., Suite 100, Lakeland, FL 33801
Fax: (863) 688-4200 ◆ Phone: (863) 688-4500 ◆ Toll-Free: (800) 430-7999 ◆ www.midamerica.biz

PLEASE SEE REVERSE SIDE

HOW TO FILE YOUR CLAIM

Section 1

Complete ALL personal information on the reverse side of this form.

Section 2

Indicate the amount of each healthcare and/or daycare claim being submitted. These accounts reimburse you for services incurred during the plan year. If you are submitting expenses for more than one plan year, please complete a new form for each plan year. The date(s) of service determines claim eligibility, not the date you pay or receive billing for the service.

BENEFIT TYPE CODES

Please refer to the example in Section 2 on the front of this page and select the proper two digit benefit type code for the expense you are claiming in each line item. This will allow for faster and more accurate processing of your claim.

HEALTH CARE EXPENSES – incurred by you, your spouse, or other eligible dependents.

Attach to this claim form one of the following:

- The insurance explanation of benefits (EOB) statement returned to you from the insurance carrier indicating the amount for which you are responsible. Remember any medical, dental, or vision expense covered by insurance in part or in full must first be submitted to your insurance carrier.
- When there is no insurance for healthcare expenses, submit an itemized bill with the following information:
  - Name of provider and patient
  - Service cost, date, and description
  - Notation when there is no insurance coverage
- Co-pay receipts if you are covered under a managed care or prescription drug plan
- Orthodontic expenses are reimbursed over the period of time the appliances are worn as described in the treatment plan your orthodontist provided to you. Send a copy of this treatment plan to our office, along with your first claim documenting the expected length, cost of service, and insurance coverage. For subsequent monthly claims, simply indicate on the claim form the amount and month you are claiming (based on treatment schedule).

Total your expenses and enter the amount on the front of this form. **Canceled checks, balance due statements, or undocumented receipts are not acceptable documentation per IRS regulations.**

DAY CARE / DEPENDENT CARE EXPENSES

Complete this section if you have incurred expenses for the care of a dependent to allow you and/or your spouse to work. This form substantiates expenses you have incurred with the provider listed on this form. Indicate the name(s) and ages(s) of person(s) who have received day care / dependent care. Copies of bills and receipts must be attached to support your request for reimbursement. Canceled checks are not acceptable documentation. If those documents are not available, you must have the provider of service sign the appropriate space and indicate tax ID number on the front of this form.

Section 3

SIGN the claim form. This is required on all submissions, otherwise the claim will not be processed.

This Flexible Spending Account is regulated by the Internal Revenue Service. Our documentation guidelines are intended as a means to qualify your expenses for approval and reimbursement. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements will delay the payment of your claim.

As a reminder, your election is irrevocable during the plan year. If allowed by your plan provisions, an election can only be changed during the plan year if you have a qualifying status change. The request has to be made timely and the requested election change has to be in line and consistent with the event.

This outline is intended for quick reference. For more specific guidelines, please call MidAmerica Administrative & Retirement Solutions, Inc. at **1-800-430-7999.**

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