

EDUCATORS

FLEXIBLE SPENDING REIMBURSEMENT FORM

852 East Arrowhead Lane * Murray, Utah 84017-5298 * (801) 262-7476

I. Employee

EMPLOYEE NAME	SS#	EMPLOYER
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Check here if new address

STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE #	WORK PHONE #		

II. Health Care Reimbursement Section

Would you like the total reimbursement amount paid in advance? Yes No

DATES OF SERVICE	NAME OF PATIENT	RELATIONSHIP TO INSURED	DESCRIPTION OF SERVICE	REIMBURSABLE AMT.
				\$
				\$
				\$
				\$
				\$

Total Reimbursable Amount: \$

III. Dependent Care Reimbursement Section

DATES OF SERVICE FROM TO	DEPENDENT NAME	AGE	RELATIONSHIP TO INSURED	PROVIDER NAME, ADDRESS, AND TIN OR SSN	REIMBURSABLE AMOUNT
					\$
					\$
					\$
					\$

Total Reimbursable Amount: \$

IV. Signature

I certify that these expenses are not reimbursable under any other benefit program and will not be claimed as an income tax deduction. I am requesting reimbursement only for qualifying expenses incurred during the plan year for eligible plan participants. I authorize my Flexible Spending Account(s) to be reduced by the amount(s) requested.

X _____ Date _____

NOTE: Please attach supporting documentation (receipts, billing statements, etc.). A separate form for each receipt is not necessary. Claims will not be processed without complete information and supporting documentation. Supporting documentation will not be returned. Therefore, be sure to keep copies of these expenses for your records.

1. Definitions

The terms listed below shall have the following meanings on the reimbursement form:

- a. **Employer-** sponsoring group or district participant is employed with
- b. **Description of Services-** i.e., Dental = cleaning, filling, crown, etc.;
Surgery = gallbladder removal, etc.

2. Supporting Documentation:

Including, but not limited to-

- a. Health Care (Medical, Dental, Vision, Prescription)
 - 1. Receipt, billing or prescription stub. These must show date of service, amount to be reimbursed, and provider name.
 - 2. Printouts from the pharmacy for prescription services must include the pharmacist signature.
 - 3. Canceled checks, copies of canceled checks, and credit card receipts are not acceptable documentation.
- b. Dependent Care (Child Care, Elderly Care)
 - 1. Receipt, billing, processed documentation. These must show date(s) of service (both beginning and ending dates), amount to be reimbursed, and include provider name, provider signature, and provider's TIN or SSN and address.

**SUPPORTING DOCUMENTATION WILL NOT BE RETURNED.
THEREFORE, BE SURE YOU HAVE COPIES OF THESE EXPENSES FOR YOUR RECORDS.**

3. Submitting Claims

- a. All completed claim forms, with supporting documentation attached, must be sent to:

Educators Flexible Spending Department
852 East Arrowhead Lane
Murray, Utah 84107-5298