REIMBURSEMENT REQUEST FORM

Fax Completed Form to: 518.792.0226 | Questions/Assistance: 866.311.7110

Use this form for reimbursement of any out-of-pocket expenses. Missing or incomplete information may result in the denial or delay of your request.

STEP 1: PARTICIPANT INFORMATION	
Employer Name	The ARC, Oneida-Lewis Chapter
Participant Name	
Participant Social Security Number	
Mailing Address	
Email Address	

STEP 2: REIMBURSEMENT INFORMATION

PLAN TYPE*	DID YOU FILE ONLINE? Y/N	DATE EXPENSE INCURRED	TYPE OF EXPENSE	Merchant or Provider Name	NAME OF PERSON RECEIVING PRODUCT/SERVICE	Relationship	AMOUNT
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$

Any person who knowingly and with the intent to defraud, injure or deceive; submits a reimbursement request containing any materially false, deceptive incomplete or misleading information pertaining to such request, may be committing a fraudulent act which is a crime and may subject such person to criminal and/or civil penalties or denial of benefits.

TOTAL REIMBURSEMENT AMOUNT REQUESTED	$

***PLAN TYPES (PLEASE REFER TO YOUR PLAN MATERIALS FOR THE PLANS APPLICABLE TO YOU):** **MFSA**-Medical Flexible Spending Account; **DCAP**-Dependent Care Assistance Program (include Tax ID or SS# of provider); **HRA**-Health Reimbursement Arrangement;

STEP 3: PARTICIPANT CERTIFICATION
To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses, incurred by myself or eligible dependents, as defined by the IRS and by my employer-sponsored Plan, and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that Jaeger & Flynn Associates, Inc., including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement and if any expenses are found to be ineligible I will be responsible for reimbursing the plan. If submitting expenses for my Dependent Care Assistance Program account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Jaeger & Flynn Associates, Inc. By submitting the form, I certify the above. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.
PARTICIPANT SIGNATURE: _____ DATE: _____

COMPLETION GUIDE

In General

- Please complete the Reimbursement Request Form fully and clearly. Missing, incomplete, or illegible information may result in the denial or delay of your request.
- Please do not highlight any of your documentation, as highlighted sections may be unreadable when reviewed.
- Please keep a copy of all documentation that you submit.

For Section 2: Reimbursement Information

- **Plan Type:** Enter the code located in the key to identify the Plan account from which you are requesting reimbursement. Note: In the event you are enrolled in/eligible for more than one Plan, and the expense you are submitting is eligible for reimbursement under more than one Plan, your employer's Plan reimbursement sequencing rules may apply.
- **Did You File Online?**: If you entered your reimbursement request information at https://jfaflex.lh1ondemand.com, please mark "Y" for "Yes".
- **Date Expense Incurred:** This is the date when you actually received the product or service, not necessarily when you paid for the expense. For instance, you may have visited the doctor on September 1st, but not been billed or paid for the office visit until October 1st. The "date incurred" is September 1st.
- **Merchant/Provider Name:** Provide the details on where the expense was incurred.
- **Name of Person Receiving Product/Service:** Provide your name or the name of the eligible dependent for whom the service was provided or product purchased. If you are claiming reimbursement for someone other than yourself, the individual must meet the definition of "dependent" under your Plan.
- **Amount:** Provide the total amount requested for each expense. This amount should be your "total responsibility" to the merchant/provider, minus any other insurance coverage that may be providing a partial benefit.
- **Total Reimbursement Requested:** Please total the amounts for each of your requested expenses. Please use additional forms as needed.

Documentation Requirements Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase was made;
- Description of service or item purchased;
- Dollar amount (after insurance, if applicable).

If you are enrolled in a Deductible Reimbursement plan, you are required to obtain and provide an Explanation of Benefits (EOB) statement from the health insurance carrier, instead of a merchant/provider receipt. The EOB clearly indicates what portion of your medical services are subject to deductible, and therefore eligible for reimbursement under your specific Plan.

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (please be advised that if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service;
- Dollar amount;
- Name of day care provider.
- Tax ID or Social Security Number of Provider

Unacceptable forms of documentation include:

- Provider statements that only indicate the amount paid, balance forward, or previous balance;
- Credit card receipts that only reflect a payment;
- Bills for prepaid dependent care/medical expenses where services have not yet been rendered.

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, please have the provider write "co-payment" on the receipt and sign it.

Send your Reimbursement Request & Documentation to:

JAEGER & FLYNN ASSOCIATES, INC. FLEX PLAN SERVICES

MAIL: 42 SOUTH STREET, GLENS FALLS NY 12801

FAX: 518.792.0226

EMAIL: JFAFLEX@JAEGERFLYNN.COM