

Yavapai County

Yavapai College

City of Prescott

Town of Chino Valley

YAVAPAI COMBINED TRUST FLEXIBLE SPENDING ACCOUNT CLAIM FORM

*Administered by: Administrative Enterprises, Inc. • 5810 W. Beverly Lane; Glendale, AZ 85306-1800 • (602) 789-1170
Fax: (602) 789-1179*

Please type or print. See reverse side for instructions and additional important information.

EMPLOYEE INFORMATION

NAME: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____

	Street	Unit No.	City	State	Zip Code
<input type="checkbox"/> Check this box if address has changed since last claim was filed	HOME PHONE: (____) _____		WORK PHONE: (____) _____		

HEALTH CARE REIMBURSEMENT

To ensure the prompt processing of your reimbursement request, please be sure to attach copies of your Explanation of Benefits statement prepared by your insurance carrier and any additional supporting documentation as described on the reverse of this form for each of the reimbursement requests listed below.

	Date of Service	Provider of Service	Amount of Reimbursement
1			
2			
3			
4			
5			
6			
7			
8			
TOTAL REIMBURSEMENT REQUEST			

DAY CARE REIMBURSEMENT

You must provide bills from your dependent care provider or other evidence that the expenses were incurred. The bills/receipt must indicate the dates of service, name and age of dependent, care providers name, address and tax ID # and total expense.

Dependent Name/Relationship	Age	Dates of Service	Amount
TOTAL REIMBURSEMENT REQUEST			

NAME OF DEPENDENT CARE PROVIDER: _____	SOCIAL SECURITY/ TAX ID NUMBER: _____
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ADDRESS: _____

Street	Unit No.	City	State	Zip Code
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EMPLOYEE SIGNATURE

I hereby request payment from my Flexible Spending Account for the expenses itemized above. I certify that I have not requested reimbursement under this Plan or from any other source for these expenses. I also certify that the total dependent care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that the expenses I am submitting for payment are eligible expenses, as explained in my open enrollment material and in I.R.S. publications 502 and 503. I understand that expenses paid through these accounts cannot be claimed on my personal income tax return.

EMPLOYEE SIGNATURE: _____ DATE: _____

IMPORTANT INFORMATION ON REIMBURSEMENTS

Health Care - Eligible Expenses: In general, you may be reimbursed for a health care expense which qualifies as a deduction on federal income tax returns. Also, the expense must not be reimbursed by any other source and must not be deducted on your income tax return. Some examples of eligible expenses include coinsurance, deductibles, vision, hearing, prescription drug expenses not covered by your health insurance, or your spouse's health insurance and dental including orthodontic expenses.

For orthodontic expenses, you will be required to submit a copy of the orthodontia contract (treatment agreement) established between the orthodontist and the responsible party. After the contract has been submitted, monthly payments will be reimbursed upon submission of a reimbursement request and a statement/receipt from the orthodontist indicating the monthly adjustment visit.

For more information about eligible expenses, you should refer to your open enrollment packet and I.R.S. publications #502 and #503.

Dependent Care - Eligible Expenses: In general, the following rules apply to dependent care expenses:

- The annual amount submitted for reimbursement must be less than the lower of your income or your spouse's income.
- The expenses must be for the care of your dependent who is under age 13 and entitled to a dependent deduction under Internal Revenue Service code section 151(e) or a dependent who is physically or mentally incapable of caring for himself or herself.
- The care must be necessary in order for you and your spouse to work.
- The payments cannot be made to a person who is claimed as your dependent.
- If the services are provided by a dependent care center which provides care for more than six individuals, the center must comply with all state and local laws.

Supporting Documentation: The following supporting documentation must be submitted with this form:

- Expenses covered by your health care plans: Medical and dental expenses covered by your health care plans must be submitted under those plans first. Attach a copy of the "explanation of benefits" statement to claim amounts not paid by your health care plans, along with an itemized receipt.

If you do not carry coverage under a health, dental or vision plan, or your policy does not provide an Explanation of Benefits, please provide a written statement of such and a copy of the receipt. The receipt must indicate the provider of service, patient name, date(s) of service, type of service rendered and the amount billed.

- Dependent Care Expenses: Complete the "Dependent Care Reimbursement" section on the front of this form and attach a signed receipt from your dependent care provider. Submit all bills or receipts with your completed claim form.
- All other expenses: For all other expenses, submit bills that clearly state:
 - Name of person receiving the service
 - Name of service or supplies
 - Name and address of service provider
 - Amount charged
 - Date service was rendered

Send completed form to: Administrative Enterprises, Inc.
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