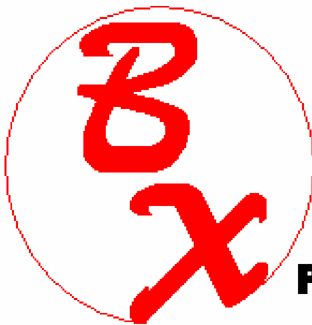
FLEXIBLE BENEFIT PLAN INFORMATIONAL PACKET

Employer Sponsored Insurance Premiums
Health Flexible Spending Account
Dependent Care Flexible Spending Account



BENEFIT EXTRAS, INC.

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INTRODUCTION

Take advantage of a benefit choice that can increase your spendable income - a flexible benefit plan. You can enhance your benefits package by participating in this valuable option available through your employer.

As a benefits eligible employee, you are eligible to enroll in the Flexible Benefit Plan. The Plan provides you an opportunity to set aside part of your pay on a pre-tax basis, thereby lowering your taxable income, reducing your social security and income taxes and increasing your spendable income.

The information contained in this enrollment packet describes the basic features of the Plan and how it operates in an effort to help you choose the benefits that best protect you and your family. This is your benefit, and it is important that you understand how it works and how it can help you.

Not all of the information contained in this informational packet may apply to your plan. For the specific details of your Plan, you should consult your Summary Plan Description. The “Highlight Sheet”, available through your employer, lists the plans available under your Flexible Benefits Plan and the maximum amounts you can contribute. Please refer to this sheet when making your Flexible Benefit Plan elections.

Please note that this enrollment packet addresses only the key components of the Flexible Benefit Plan. Consult the Plan Document or Summary Plan Description for more details.

PREMIUM CONVERSION PLAN

The Premium Conversion Plan allows employees who have payroll deductions for employer-sponsored health insurance premiums to increase their take-home pay since these payments are not subject to federal, state and FICA taxes. If you do not elect to participate in the Premium Conversion plan, you still have to pay your share of the health insurance premiums under the Company's health care program but on an after-tax basis.

The contribution necessary to obtain the Company's health care benefits will be communicated by your Employer upon commencement of participation at the time of enrollment.

FLEXIBLE SPENDING ACCOUNTS

❋HEALTH CARE FLEXIBLE SPENDING ACCOUNT

By enrolling in a Health Care Flexible Spending Account, employees are able to pay for eligible out-of-pocket medical and dental expenses on a pre-tax basis with deductions taken directly from salary. These deductions reduce an employee's gross income on his/her Form W-2 for federal, state and social security tax purposes. These deductions are spread out evenly over each payroll and allocated to your Flexible Spending Account for reimbursement of covered expenses. By participating in the Health Care Flexible Spending Account, employees and their spouses are **disqualified** from having a Health Savings Account.

❋DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

By enrolling in a Dependent Care Flexible Spending Account, employees are able to pay for eligible dependent care expenses on a pre-tax basis with deductions taken directly from salary. The maximum you may deposit to a Dependent Care Flexible Spending Account is $5,000 per year ($2,500 if married filing a separate tax return) or the lesser of you or your spouse's earned income.

Please refer to the "Highlight" sheet for accounts available under the Plan and the maximum amounts you are eligible to set aside.

HOW DOES THE PLAN SAVE ME MONEY?

The following example illustrates how the Plan saves you money. Assume that your monthly share of the health insurance premium is $250 per month, your monthly income is $2,000, and you are in the 15-percent federal income tax bracket and the 7.5-percent state income tax bracket. Assume also that you expect to have $2,400 in uninsured medical expenses during the year. If you pay your health insurance premiums using the Premium Conversion Plan and your uninsured medical expenses using the Health Care Flexible Spending Account, you will save $126 per month, or $1,512 per year. These amounts are computed as follows:

	Pre-Tax Medical Plan	No Pre-Tax Medical Plan
Salary	$2,000	$2,000
LESS:		
Health Insurance Premium	(250)	0
Uninsured Medical Expenses	(200)	0
Taxable Income	$1,550	$2,000
LESS:		
Federal Income Tax (15%)	(233)	(300)
State Income Tax (7.5%)	(116)	(150)
*Social Security FICA (5.65%)	(88)	(113)
Health Insurance Premium	0	(250)
Unreimbursed Medical Expenses	0	(200)
Net Take Home Pay	$1,113	$987
Monthly Tax Savings	$ 126	
Annual Tax Savings	$1,512	

*Takes into account employee's reduction to FICA taxes effective 1/1/2011.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

WHAT IS A HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

A Health Care Flexible Spending Account allows you to set aside tax-free money to cover eligible health care expenses you incur for you and your eligible dependents during the plan year. Eligible dependents include your spouse and your adult child who as of the end of the taxable year has not attained age 27 and regardless of whether or not this individual is a full-time student, disabled or married. **By participating in a Health Care Flexible Spending Account, you and/or your spouse are disqualified from contributing to a Health Savings Account.**

ELIGIBLE HEALTH CARE (MEDICAL/DENTAL) EXPENSES

Eligible health care (medical/dental) expenses are expenses that are "medically or dentally necessary." This means the expenses must be for the diagnosis, treatment or prevention of disease and for treatment affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. In addition, to qualify as a reimbursable health care expense the medical, dental, vision or hearing expense must:

- be incurred (received) during your eligible period of coverage; and
- not be reimbursable from any other health insurance or reimbursement program.

Expenses incurred prior to the plan year start date or prior to your effective date are not eligible for reimbursement. Expenses incurred after your termination of employment or after the plan year end date are also not eligible for reimbursement. Certain plans may include a grace period. Please refer to your plan documents.

The IRS imposes certain restrictions on Health Care Flexible Spending Accounts, including the following:

- Authorized salary reductions into your Health Care Flexible Spending Account may not be changed for the rest of the year unless you terminate employment or have a change in family status. Changes in family status are discussed in your Summary Plan Description.
- You will forfeit all unused funds in your Health Care Flexible Spending Account at the end of the plan year. ***This is the "use or lose" rule***. Unused balances may not be carried over to the next plan year or converted to cash. For this reason, you should estimate your anticipated expenses for the plan year conservatively.
- You will receive a statement shortly after the start of the plan year. Here you will receive information as to how to log onto our website and view your account information. As indicated above, these amounts must be used by the end of the plan year or during the grace period or they will be lost (refer to your Highlight Sheet or SPD to determine whether a grace period is provided). You may continue to submit claims up to 90 days after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given **90** days from their date of termination in which to submit expenses incurred prior to their termination.

Please refer to the "Highlight" sheet to see if this account is available under your Company's Flexible Benefit Plan and the maximum amount you may contribute.

ELIGIBLE EXPENSES

The following list gives examples of the types of health care expenses that may be eligible. Only expenses that are not reimbursed by insurance or another reimbursement program can be claimed. Expenses for cosmetic procedures that are not medically necessary are not eligible for reimbursement. This list is compiled from IRS Publication 502, which you may obtain from the Internal Revenue Service.

✓Alcoholism Treatment
✓Ambulance
✓Artificial Limb
✓Birth Control Pills
✓Braille Books and Magazines
✓Breast Pumps
✓Chiropractor
✓Co-payments or Co-insurance (Amounts you pay)
✓Crutches
✓Deductibles under Medical/Dental Plans (Amounts you pay)
✓Dental Treatment
✓Eyeglasses and Eye Exams
✓Expenses in Excess of Medical/Dental Plan Limits
✓Hearing Aids
✓Hospital Services
✓Insulin
✓Laboratory Fees
✓Laser Eye Surgery
✓Orthodontia
✓Orthopedic Drugs
✓Over the Counter Items (see following page)
✓Prescription Drugs
✓Routine Physicals
✓Sterilization Fees
✓Stop Smoking Programs
✓Surgical Fees
✓Telephone (Special for the Deaf)
✓Therapy Programs
✓Tuition at Special School for the Challenged
✓Weight Loss Programs
✓Vision Care
✓Wheelchair
✓X-rays

INELIGIBLE EXPENSES

The IRS specifically disallows reimbursement for expenses that benefit or maintain overall good health or that is as a result of a personal decision where no disease or defect is present. This is a partial list of medical care expenses not eligible for reimbursement.

✓Clip-on Sunglasses
✓Cosmetic Surgery
✓Custodial Care
✓Diaper Service
✓Divorce Expenses
✓Ear Piercing
✓Electrolysis
✓Exercise Program
✓Face Lift
✓Fitness Program
✓Funeral Expenses
✓Health Club Membership
✓Herbal Remedies
✓Illegal Drugs
✓Insurance Premiums
✓Late Fees or Interest Charges
✓Liposuction
✓Marriage Counseling
✓Maternity Clothes
✓Meals
✓Over-the-Counter Drugs (see following page)
✓Personal Use Items
✓Non Prescription Safety Glasses
✓Teeth Bleaching or Teeth Whitening
✓Teeth Guards
✓Tooth Bonding
✓Union Dues

Important note: Effective January 1, 2011 OTC drugs or medications are not eligible for reimbursement without a prescription. A valid prescription must include the name(s) and address of the patient(s); name and quantity of the drug prescribed and directions for use; specific medical condition requiring the use and the date of issue. A doctor's note of medical necessity does NOT meet the definition of a valid prescription.

Eligible Over-the-Counter items reimbursable as of 1/1/11 without a prescription ~Items used for "medical care" (to alleviate or treat personal injuries) are reimbursable under the health care flexible spending account. Some examples of eligible over-the-counter items that can be reimbursed are:

✓First aid supplies (i.e. thermometers, ace bandages)
✓Contact lens solutions/cases
✓Insoles
✓Wrist/ankle braces/supports
✓Pregnancy tests
✓Reading glasses
✓Test strips
✓Blood pressure monitors
✓Crutches

Over-the-Counter Drugs or Medications reimbursable <u>only</u> with prescription as of 1/1/11~

✓Acid controllers
✓Antibiotic products
✓Anti-gas
✓Aspirin / pain relief
✓Cold sore remedies
✓Digestive aids
✓Hemorrhoid preps
✓Allergy & sinus
✓Anti-diarrheal
✓Sleep aids
✓Medicated ointment/creams
✓Cough, cold & flu
✓Anti-fungal / anti-itch
✓Laxatives

Ineligible Over-the-Counter Drugs (these products are not considered medical care and therefore are NOT reimbursable through the plan):

✓Mouthwash
✓Oral anesthetics
✓Shaving cream / razors
✓Soap / shampoo
✓Teeth whitening kits
✓Toothpaste
✓Lotions, anti aging cream
✓Q-tips
✓Chap stick / lip balm
✓Cosmetics
✓Cotton balls
✓Deodorants
✓Feminine hygiene products
✓Vitamins taken for your general health

Claim Substantiation As with any claim submitted under the health care flexible spending account, Benefit Extras requires a receipt from a third-party substantiating the expense. In the case of an eligible over-the-counter item, the eligible receipt will commonly be the cash register receipt. If the cash register receipt does not clearly indicate the item(s) purchased, please provide this information either on the front of the claim form or directly on the cash register receipt. If this information is not provided at the time you submit your claim, your claim will be returned requesting the additional information.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

One of the most important issues to a working parent is childcare. Not only is it difficult to find and arrange for good childcare, it can be very expensive. Also, with our aging population, many people are caring for elderly or disabled dependents that are unable to care for themselves.

WHAT IS A DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT?

The Dependent Care Flexible Spending Account is designed to give you a tax saving way to pay for these expenses. This account works much like the Health Care Flexible Spending Account – with a few twists.

It is important to remember that the dependent day care expenses must meet certain IRS requirements. The expenses must be necessary for you to continue working. If married, you and your spouse must both be working, or your spouse must be a full-time student or disabled.

To be considered a "dependent," the person receiving care must be eligible to be claimed as your dependent on your federal income tax return and be either:

- under the age of 13; or
- your spouse or other dependent who is physically or mentally incapable of self-support, and who spends at least 8 hours per day in your home.

USING TAX-FREE DOLLARS TO PAY FOR EXPENSES

With a DCRA you can set aside money to cover these expenses on a tax-free basis. This way you save money because you never have to pay taxes on the money you set aside in the account. For example, if you incur $2,000 of eligible dependent (day) care expenses in a year, you could save about $603 in income taxes:

With a Flexible Spending Account		Without A Flexible Spending Account
$24,000	Salary	$24,000
-2,000	Pretax Child Care	0
-----------		-----------
$22,000	Taxable Income	$24,000
-6,160	*Taxes (28%)	-6,720
-----------		-----------
$15,840	After-Tax Income	$17,280
0	After-Tax Child Care	-2,000
-----------		-----------
$15,840	Take-Home Pay	$15,280

*Takes into account employee's reduction to FICA taxes effective 1/1/2011.

REIMBURSABLE DEPENDENT (DAY) CARE EXPENSES

To qualify as a reimbursable dependent (day) care expense, the expense must be incurred during the plan year. Any dependent (day) care expenses incurred *prior* to the plan year are not reimbursable.

SETTING UP AN ACCOUNT

To set up a Dependent Care Flexible Spending Account, you must first decide how much money to set aside for the plan year. You may deposit any amount up to $416 a month ($5,000 annually for a full plan year). Your maximum amount is $208 a month if you are married filing a separate income tax return. The IRS limits the amount of money you may redirect to the smallest of:

- your income,
- your spouse's income, or
- $5,000 per family ($2,500 if married filing separate returns).

There are special IRS provisions if your spouse is a full-time student or is disabled.

SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES

Under current law, a tax credit is available for dependent day care expenses of the same type eligible for reimbursement through the Plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 20% to 35% of eligible expenses up to a limit of $3,000 of expenses if there is one eligible Dependent and $6,000 of expenses if there are two or more eligible Dependents. You will not be eligible to take the tax credit for any expenses reimbursed through the Plan. In addition, the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent day care reimbursements you receive under the Plan.

Determining whether taking the credit or reimbursement under the Plan is more beneficial involves complex calculations. Because each individual's situation is different, the Employer cannot predict whether or not it would be more beneficial for you to take the tax credit for dependent day care expenses or to have your expenses reimbursed under the Plan. You may want to consult your tax advisor to determine whether the tax credit or Dependent Care Flexible Spending Account is more beneficial to your personal situation.

HEALTH CARE AND DEPENDENT CARE ACCOUNT WORKSHEET

The purpose of this worksheet is to determine the medical, dental, vision or dependent care (day care) expenses for which you are not reimbursed from any other benefit plan. Be conservative and estimate only those expenses you are reasonably certain you will incur during the plan year. Under the ***"Use or Lose"*** provisions, if you allocate too much money to your account and cannot use the money by the end of the Plan Year, you forfeit the remaining balance.

ESTIMATED UNREIMBURSED HEALTH CARE EXPENSES

	Annual Amount
Medical Deductibles/Co-payments	____________
Medical Supplies (Prescribed by physician)	____________
Other Medical Providers (Chiropractic, podiatrists, etc.)	____________
Annual Physical Exam	____________
Dental Deductibles/Co-payments	____________
Dental Expenses (Exams, cleaning, fillings, etc.)	____________
Prescription Drug Deductibles/Co-payments	____________
Vision Care (Eye exams, contacts, eye glasses)	____________
Orthodontia	____________
Any Other Eligible Expenses	____________
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR	____________

NUMBER OF PAY PERIODS IN THE PLAN YEAR (or partial year, if applicable)______

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS ____________*

*Enter result on the enrollment form under Health Care Flexible Spending Account Elections PER PAY PERIOD amount.

Please Note: You can only change this health care election if there are significant changes in your family status. Consult the Plan Document or Summary Plan Description for more details.

ESTIMATED DEPENDENT CARE (DAY CARE) EXPENSES

	Annual Amount
Day Care for Eligible Dependents	____________
Pre-School Educational Programs	____________

TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR ____________

NUMBER OF PAY PERIODS IN THE PLAN YEAR (or partial year, if applicable)______

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS ____________**

**Enter result on the enrollment form under Dependent Care Flexible Spending Account Elections PER PAY PERIOD amount.

Please Note: Regulations enacted as of January 1, 2001 may allow you to change this dependent care election, as your day care needs change during the plan year. Consult the Plan Document or Summary Plan Description for more details.

IRS REGULATIONS

THE "USE OR LOSE" RULE

Remember the important ***"use or lose"*** rule when deciding how much to place in your account:

- If you contribute dollars to a flexible spending account and do not use all of the monies you deposit, you will lose any remaining balance in the account at the end of the plan year or, if part of the Plan, the corresponding grace period (refer to your Highlight Sheet or SPD to determine whether a grace period is provided).
- Because of the tax advantages of a flexible benefit plan, the IRS has established strict guidelines for monies not used by the end of the plan year or, if part of the Plan, the corresponding grace period (refer to your Highlight Sheet or SPD to determine whether a grace period is provided). For this reason, plan carefully how much to place in your account. *Only contribute those dollars you are confident you will use to pay for qualified expenses incurred during the plan year* or, if part of the Plan, the corresponding grace period (refer to your Highlight Sheet or SPD to determine whether a grace period is provided).

ONCE ENROLLED, YOU MAY NOT CHANGE

To comply with IRS regulations, you may only make a change in your election at the beginning of each plan year. This means you may not make a change in your elections after the open enrollment period unless you experience a family status change. Examples include - marriage, divorce, birth, adoption, death, loss of spouse's employment, etc.

Please Note: Regulations enacted as of January 1, 2001 may allow you to change your dependent care election, as your day care needs change during the plan year. Consult the Plan Document or Summary Plan Description for more details.

Be sure to contact your employer if any of these changes apply to you so that you can complete a "Change in Participation" form. Your completed form must be received within 30 days of the change to make a new election.

Please refer to your Summary Plan Description to see if a change of election is acceptable for your change in status.

SOCIAL SECURITY BENEFITS

Any reduction in your taxable pay for Social Security purposes may also lead to a reduction in your Social Security benefits. For most employees, the reduction in Social Security benefits will be insignificant compared to the value of paying lower taxes today.

SEPARATE ACCOUNTS

Under IRS regulations, each flexible spending account (FSA) is separate and is not interchangeable. Dependent (Day) care may only be reimbursed under the Dependent (Day) Care FSA and unreimbursed medical expenses may only be reimbursed through the Health Care FSA.

ENROLLMENT INSTRUCTIONS

As a benefit eligible employee, you are required to complete an election form prior to the date you first become eligible for the plan or prior to the first day of each plan year.

The election form has the following Sections you need to complete.

- **Section I: Employee Information** – Please print all the requested data.

- **Section II: Account Elections** – This section is subdivided to reflect the three parts of the plan. Please refer to the enclosed "Highlight" sheet for available accounts and maximums under your Employers Flexible Benefit Plan.

  1. Pre-tax Premium Election – If you are currently paying a portion of your medical and/or dental premiums, this amount may be paid on a pre-tax basis.

  2. Health Care Flexible Spending Account – Use the Health Care Expense Worksheet to calculate the amount of health care expenses you will have to pay out of your pocket during the plan year. Decide how much of this amount you wish to contribute, up to the plan maximum. Your annual election will be divided equally by the number of payrolls in the plan year.

  3. Dependent Care Flexible Spending Account – Using the Dependent (Day) Care Worksheet, calculate the amount of eligible day care expenses you will have during the year. Decide how much of this amount you wish to contribute annually up to the plan maximum. Your annual election will be divided equally by the number of payrolls in the plan year.

To waive participation in the Flexible Benefit Plan

- Account Elections – Indicate your desire not to participate by checking the applicable box(es). Except for a change in status, you will not be able to elect pre-tax benefits until the next anniversary date and any after-tax coverage will be outside the plan.

Sign and date the form.

Enrollment/Change Form
Flexible Spending Accounts

Instructions:

Check one box, complete the sections, Sign and date the form	☐ New Plan Year Election (New hires) (Complete sections I and II) ☐ Change for the Plan Year (Complete sections I, II and III)

Section I – Employee Information (Please print)

Social Security #	Location/Division		
Participant Name (Last, First, MI)		Date of Birth	
Home Address	City	State	Zip

Section II- Account Elections (Please complete items 1, 2, 3 & 4)

1. Pre-tax Premium Election: I elect to have my required employee contributions withheld on a pre-tax basis for these coverages. (Availability of plans and contributions necessary to obtain coverage will be communicated by your employer prior to participation.)
Check the box for the coverage premium(s) you are electing ☐ Medical ☐ Dental
☐ **I do not wish to make a pre-tax premium election.**

2. Health Care Flexible Spending Account: I elect $____________ per payroll or $__________ for the plan year to be contributed on a pre-tax basis to my Health Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year. *I understand that by participating in the health care flexible spending account I (and my spouse) am disqualified from having a Health Savings Account ("HSA").*
☐ **I do not wish to participate in the Health Care Flexible Spending Account.**

3. Dependent Care Flexible Spending Account: I elect $____________ per payroll or $_________ for the plan year to be contributed on a pre-tax basis to my Dependent Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year.
☐ **I do not wish to participate in the Dependent Care Flexible Spending Account**.

I hereby authorize my employer to deduct from my pay on a pre-tax basis the amounts elected above for the Plan Year. I understand that the payroll deducted amount will be available for the reimbursement of my qualifying expenses incurred during the Plan Year (or grace period, if part of the plan) and/or for the payment of my premiums in accordance with the terms of the formal Plan Documents and while I am a participating employee.

Employee Signature ____ Date _______________________

Section III – Election Changes (Check the proper box, indicate the date of the change, sign & date the section)

Complete this section only if you are eligible to enroll mid-year or change your previous election due to a family status change. Mid-year enrollments and election changes MUST be requested within 30 days of the change.

☐ Marriage
☐ Divorce
☐ Birth or Adoption of Child
☐ Commencement or Termination of Employment of Spouse
☐ Change from Full-Time to Part-Time or Part-Time to Full-Time status by employee or employee's spouse
☐ Significant Change in Health Coverage due to Spouse's Employment
☐ Change in Cost/Coverage to Daycare
☐ Death of Spouse or Child
☐ Termination of Employment
☐ Other:

I hereby revoke my previous deduction authorization for the current Plan Year and authorize my employer to make the payroll deductions indicated above for the remainder of the Plan Year.

Employee Signature __________________________________ Date ___________________________________

Section IV for Employer Use Only (Employer Must Complete This Section For Any Changes)

Plan Sponsor / Employer Name ______________________________ Location _________________
Effective Date ____ 1st Payroll Change__________________
Signature of Plan Administrator ____

BENEFIT EXTRAS, INC. (Fax #952-435-8435)

REIMBURSEMENT PROCEDURES

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

To receive reimbursement you must complete a Flexible Spending Accounts claim form and attach the required substantiation. Once approved, you will be reimbursed the full amount of your eligible expenses up to your elected Health Care Flexible Spending Account limit.

Claim Reimbursement Documentation Required:

- A completed (and signed) Flexible Spending Accounts claim form; and
- If the expense is covered by insurance (this includes your deductible, which is a covered expense), an Explanation of Benefits (EOB). An EOB is a statement from the insurance carrier that explains how much of the health care charges will be paid by insurance.
- If the expense is covered by an HMO, a receipt or an invoice that clearly identifies the name of the service provider, the date of service, the service rendered and the cost of service.
- If the expense is not covered by insurance, HMO, or paid at a reduced rate, a receipt or an invoice that clearly identifies the name of the service provider, the date of service, the service rendered and the cost of service.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A completed (and signed) Flexible Spending Accounts claim form, which shows the name of the provider, the dates of service, the cost of service, the amount incurred and the TIN or SSN for that provider. Section Three must be completed, signed and dated by the service provider.

Dependent (day) care claims are reimbursed in an amount equal to the balance in your account. Any unpaid requests will be automatically considered for reimbursement as more dollars are contributed from your pay to your Dependent Care Flexible Spending Account.

Incomplete or incorrect documentation will delay processing of claims.
Instructions for completing the claim form are also provided on the form.

Mail or Fax Claim To:	**Benefit Extras, Inc.** **P.O. Box 1815** **Burnsville, MN 55337** **Phone: (952) 435-6858**	**Flex Spending** **Accounts Claim Form** **Fax: (952) 435-8435**

1. Employer/Employee Information (Must be completed)

Employer
Employee Name

Complete address below ONLY if it has changed

Street		
City	State	Zip
Soc. Sec. #	Date of Birth	

2. Instructions for Completion

- Fill out the date, description and amount of expense, attach receipts, **sign** and date the form. If applicable, indicate whether the claim is to be paid under the Grace Period provision of the Plan (not available with all Plans).
- Eligible receipts **must** include provider name, date of service, service provided and cost.
- **Note:** Canceled checks, copies of checks, credit card statements and credit card slips are not receipts.
- Claims will be processed upon receipt, compliant with the sufficient balance requirement for dependent care spending accounts.
- The summary plan description provides eligibility rules for unreimbursed medical and dependent care expenses.

3. List of Expenses

Health:	*Date Expense Incurred	Description of Expenses	Amount
	____________________	____________________	____________
	____________________	____________________	____________
	____________________	____________________	____________
	____________________	____________________	____________
		Total $	____________

***GRACE PERIOD (does not apply to all employer groups – consult your employer for details)**

☐ **By checking this box, I am requesting the attached claim(s) be reimbursed with carry over dollars from the last plan year under the Grace Period provision of the Plan. I understand that by not checking the box, my claim will be processed under the plan year in which the expense(s) was incurred and that I may NOT request the claim be re-processed at a later date. The Grace Period provision does NOT apply to the Dependent Care Account.**

Dependent Care:

Name Of Provider	Provider Tax ID#	Dependent Name	Age	Dates of Service	Amount
				Total $	____________

____________________________ ____________________

Dependent Care Provider Signature **Date**
(Required unless submitting a receipt)

4. Employee Certification

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement under my account. I have attached WRITTEN PROOF (receipts) of these expenses and I (or we) will not use the expenses reimbursed through this account as deductions or credits when filing my (our) individual income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement. In the event that any reimbursement that I may claim and receive under this plan is later determined by the IRS to be unsubstantiated, I hereby acknowledge and accept responsibility for any adverse tax consequences that may result to me. I understand the employer does not accept responsibility for direct payment to any individuals other than the employee.

X______________________________________ ________________________

Employee Signature (Required) **Date**

Questions about the Plan?

The Summary Plan Description (SPD)
is designed to explain the plan in detail
and answer your questions.
A Summary Plan Description is to be
provided to you at the time of enrollment.

If you have questions regarding a particular
reimbursement request, you should contact the
Benefit Extras, Inc.'s Flexible Benefit Department:

Benefit Extras, Inc.
P.O. Box 1815
Burnsville, MN 55337
Phone: (952) 435-6858; Toll-free 1-866-435-6858
Fax: (952) 435-8435; Toll-free 1-800-886-8793
Email: flex@benefitextras.com
Visit us on the web @ www.benefitextras.com

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