Request for Reimbursement form

Participant name	Social Security number XXX-XX-
Home address	☐ Check here if new address
Employer	Daytime phone number

Medical expenses

Attach third-party documentation showing the date of service, type of service, and out-of-pocket cost for each expense listed.
Canceled checks, credit card receipts, or statements showing only a balance due on your account are not acceptable types of documentation

Did you use your Flex Debit Card?	Date(s) of service mm/dd/yy - mm/dd/yy	Patient	Expense type	Expense amount	Admin use only
Yes No					
Yes No					
Yes No					
Yes No					
Yes No					
Yes No					
Yes No					
Yes No					
			Total		

Dependent daycare expenses

Attach a Provider statement that includes the provider's name and tax ID and the dates and cost of care OR the Provider can sign the section below.
Canceled checks, credit card receipts, or statements showing only a balance due on your account are not acceptable types of documentation.

Start date of service	End date of service	Dependent name	Expense amount	Admin use only
		Total		

Dependent daycare provider signature (if no receipt is provided)

I certify that the above listed Dependent Care services have been provided.

Daycare provider signature	Tax ID number	Date

Participant statement

Read Carefully: *I certify and understand the following: 1) expenses are considered as having been received on the date the covered individual (myself, my spouse or a person whom I am entitled to claim a reimbursement) is provided with the care; not when the service is billed or paid; 2) were not incurred for general health or cosmetic purposes; 3) have not been and will not be reimbursed under this or any other plan covering health benefits; and 4) will not be claimed as a tax credit or deduction. I understand that in accordance with IRS regulations I must provide third-party documentation for these expenses, that I have a right to appeal a denied claim, and that if an appealed claim is denied a second time, the decision of the Plan Administrator will be final.*

Participant signature	Date

Mailing address: TASC Customer Care, PO Box 2517, Appleton, WI 54912-2517
Phone: 800-236-3539 | Fax: 888-244-2759 | Email: flexcustomercare@tasconline.com | Website: bmoflex.com

Important FSA/HRA and dependent care account information

- The Health Care FSA/HRA accounts reimburse eligible medical expenses for you, your spouse and other qualified individuals. Certain over-the-counter supplies and equipment may be eligible if used for medical purposes. General health and cosmetic expenses, toiletries and vitamins/supplements are generally ineligible.
- The Limited FSA offers employees with coverage that is compatible with Health Savings Account (HSA) coverage. Eligible expenses are limited to dental and vision services.
- The IRS requires third-party documentation showing the date of service, type of service and out-of-pocket cost for each expense listed.
- Additional documentation may be required for personal and dual use expenses.
- Orthodontia expenses require an orthodontic treatment plan from your orthodontist/dentist. Expenses are reimbursed over the entire treatment period and typically span more than one plan year.
- The Daycare FSA reimburses eligible work-related day care for your child (under age 13) or other qualified individuals.
- The Provider can complete and sign this section or attach a Provider statement including the provider's name, tax ID or Social Security number, dates of service and the amount paid.

Important claim filing information

Submitting a claim

Complete this form by describing the service or expense in the area provided. Print, sign, attach supporting documentation and submit by mail, fax or e-mail to the address listed on the reverse side of this form. Claims are considered submitted when received by TASC We are able to verify claims have been received when more than three days have elapsed from the date the claim was submitted. Approved claims are posted to bmoflex.com within three business days of receipt.

Documentation requirements

Under IRS and Treasury regulations, all payments from your reimbursement account require third-party documentation. Proof of Claim Forms and the relevant documentation must be retained on file for your own personal audit purposes. Copies of documents, records and information relevant to the appeal of denied claims are available free of charge upon written request. Requests for copies not related to the appeal of denied Flexible Spending Account claims are subject to a $25 minimum copy/handling charge.

Reimbursements

Fully documented claims are generally reimbursed within three business days of receipt. Check reimbursements are mailed to your home. Direct deposits reach your financial institution within two business days of issue. Participants are responsible for verifying that funds are available in their account prior to spending them. Failure to notify TASC Customer Care of closed or changed accounts may result in delayed payments. Contact our office if you do not receive reimbursement after ten (10) business days of the form being submitted.

Period to request reimbursements

Reimbursement requests may be made for eligible health care and/or dependent daycare expenses under the respective account by submitting a proof of claim form documenting the requested service or expense within your coverage period. Refer to your Plan's Summary Plan Description (SPD) for details when claims must be submitted for reimbursement. Your company's Plan Document governs all plan provisions.

Privacy

Account information that is protected under HIPAA privacy rules will not be disclosed without your consent.

Internal Revenue Service (IRS)

Failure to comply with IRS requirements will delay a reimbursement. Any person who knowingly files claims containing false or misleading information may be guilty of a criminal act punishable under law.

TASC