

PLEASE READ THE INSTRUCTIONS ON THE BACK PRIOR TO COMPLETION.
KEEP A COPY OF THIS FORM FOR YOUR RECORDS. SEND COPIES OF ORIGINAL RECEIPTS.

PERSONAL DATA

Name: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SS# or FBMC ID Number: _____ Employer: _____ Day Time Phone: _____

Please note, FBMC does not update addresses based on the information provided on this form; therefore, in order to ensure you receive your reimbursement check, contact your agency GIR with any address change.

I understand, agree and certify to the following:

- I will use my FSA to only pay for IRS-qualified expenses, permitted under my Employer's plan(s), provided to me and my IRS-eligible dependents, on the date(s) indicated below as being incurred within my period of coverage under the applicable plan year.
- I will request reimbursement only after the services have been provided.
- I have not and will not seek reimbursement through any other source, and will exhaust all the other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my FSA.
- I specifically release my Employer and FBMC from any liability resulting from either my participation in any FSA or for any misrepresentation I make regarding my requests for reimbursement.
- I have read and understand the information on the front and back of this form.
- If I participate in my Employer's DCAP FSA Plan, I will file a Form 2441 with my income tax return and provide any taxpayer identification number required.
- The dependent care expenses I submit for reimbursement were incurred to allow me and my spouse (if married) to work or actively look for work.

 **Participant's Signature:** _____ **Date:** _____

(Required to process claim/reimbursement)

PAYMENT TYPE Place a check mark [✓] in the box(es) and fill in claim amount of any that apply below (MCAP FSA expenses ONLY):

- A.** I used the FBMC payment card to pay for these expenses (must attach documentation for transactions indicated in blue on the statement).[†] \$ _____
- B.** Please pay me for these out-of-pocket expenses (documentation must be attached).[†] \$ _____
- C.** Please apply attached documents as substitution toward card transactions requiring documentation. Use this option to substitute an ineligible charge or to substitute lost documentation.[†] \$ _____

MCAP Fill out completely (use for eligible medical expenses for yourself and qualifying dependents). You may check more than one box.

CHECK (✓) PAYMENT TYPE			Name of Person Receiving Service	Relationship to Employee	Provider of Services*	SERVICE DATE:**		AMOUNT THAT IS YOUR RESPONSIBILITY
A. Card	B. Pay me	C. Sub. docs.				FROM:	TO:	
								\$
								\$
								\$
								\$
								\$
								\$
TOTAL THIS PAGE								\$
GRAND TOTAL FOR MULTIPLE PAGES								\$

DCAP Fill out completely (use for childcare, dependent care and elder care services)

Name of Person Receiving Service	Relationship to Employee	Age and Grade	Name and Address of Persons or Facility Providing Service	SERVICE DATE:**		AMOUNT OF REIMBURSEMENT
				FROM:	TO:	
						\$
						\$
						\$
TOTAL THIS PAGE						\$
OR ATTACH STATEMENT / BILL : _____						\$
GRAND TOTAL FOR MULTIPLE PAGES						\$

SIGNATURE OF DAY CARE PROVIDER (LISTED ABOVE)

[†] Please remember to keep copies for your records.

* "Provider of Services" means name of hospital, doctor, dentist, drugstore, medical supply store, etc.

** "Service date" refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it.

FBMC

Mail to: P.O. Box 1810, Tallahassee, Florida 32302-1810

Toll-Free Fax to: **1-866-440-7152** or General Fax to: **(850) 514-5817**

Customer Service: 1-800-342-8017 Interactive Benefits Information Line: 1-800-865-3262

INSTRUCTIONS FOR FSA REIMBURSEMENT

Important Requirements

- Submit copies of statements, bills, receipts or Explanation of Benefits (EOBs) in the same order as listed on the claim form.
- **DO NOT USE a highlighter** on your documentation! The highlighted text becomes unreadable once it is scanned into the system.
- Retain a copy of the completed claim form and all documentation for your records.
- Credit card receipts and canceled checks cannot be used to approve your claim.

Documentation Requirements

- **MCAP** * – a copy of the receipt, invoice or bill from the provider showing the date services were received, the cost of the services, the type of services incurred and the name of the person for whom the services were provided. An EOB may be submitted in lieu of a statement, receipt or bill for medical services. Pharmacy receipts must indicate the name of the drugs obtained.
- **Orthodontics** * – a written statement from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service and the cost for the service, as well as a copy of the patient's contract if reimbursement is to be spread over a period of time. **Note:** Reimbursement of the full or initial payment may only occur during the plan year in which the braces are first installed.
- **DCAP** – if the provider signs the form, no further documentation is required. If the provider does not sign the form, you can submit a receipt, invoice or bill that indicates the name and address of the provider, the beginning and ending dates of the provided services, the cost of the services and the name of the eligible dependents.

* In addition to the documentation noted above, some services may require additional documentation such as a Letter of Medical Need, a Capital Expense Letter or a Personal Use Letter. Go to www.myFBMC.com for a description and copies of the forms.

Personal Data Section

- Complete this section in full.
- FBMC does not update addresses based on the information provided on this form. In order to ensure you receive your reimbursement check, you must change your address through your agency GIR.
- **SSN or FBMC ID#** – enter your Social Security Number or 16-digit FBMC ID #. Your FBMC ID # can be found on your monthly statement or on FBMC's website after logging in.
- **Participant's Signature** – the employee must sign and date the form.

Medical Care Assistance Plan (MCAP), including the FSA Payment Card, Section

- Complete this section if you are submitting medical expenses for reimbursement or if you are sending backup documentation to validate an FSA payment card transaction. **You may mark more than one box, if applicable.**
- **'A. Card'** – check box 'A' if you are sending documentation to substantiate an expense that you used your FSA payment card to pay. Transactions that need documentation are indicated in blue on your monthly statement (or red on FBMC's website).
- **'B. Pay Me'** – check box 'B' if you are sending documentation for an eligible medical expense that you paid out of pocket.
- **'C. Sub. Docs'** – this box is only for employees who use the FSA payment card. If the FSA payment card was swiped for an ineligible expense (or an expense that you were partially or entirely reimbursed by insurance), mark box 'C' in order to substitute an expense that you paid out-of-pocket. By checking box 'C', the non-card transaction will be substituted to cover the ineligible portion of the card transaction; any remaining balance will be paid to you, if you have a remaining account balance. **Note:** If your FSA payment card is suspended or if 60 days has passed since the card was used for an ineligible claim, the next 'Pay Me' claim (i.e., non-card claim) you submit for payment will be substituted automatically.
- **Name of Person Receiving Service** – indicate the first and last name of the person who received the medical service or medication.
- **Relationship to Employee** – indicate whether the person receiving the service was your spouse, son, daughter, mother, father, etc.
- **Provider of Services** – indicate the specific name of the provider, such as Dr. Smith or Walgreens.
- **Service Date** – in many cases, the 'From' and 'To' dates will be the same date. In cases of a hospital stay spanning more than one day, enter the date you went into the hospital in the 'From' field and the date you were released in the 'To' field. For medical services, indicate the date that services were received – not necessarily when paid. Prescriptions may also be indicated in the 'From' and 'To' fields. For example, if you had six prescriptions that were filled, regardless of the date they were picked up) from February 1 through February 28 you could indicate 2/1/20xx – 2/28/20xx in these fields.
- **Amount That is Your Responsibility** – indicate the portion of the expense that you are responsible to pay (for example, co-payments, deductibles and amounts over what insurance paid).
- **Total this Page** – total all entries in the 'Amount that is Your Responsibility' column.
- **Grand Total For Multiple Pages** – add the 'Total this Page' box together for all pages if you are submitting more than one page of claims. Enter the grand total in this box. **Note:** Make sure you complete the 'Page ___ of ___' at the top of the claim form.

Dependent Care Assistance Plan (DCAP) Section

- Complete this section if you have dependent care expenses you want to submit for reimbursement.
- **Name of Person Receiving Service** – indicate the first and last name of the person who is receiving dependent care.
- **Relationship to Employee** – indicate whether the person receiving the service was your spouse, son, daughter, mother, father, etc.
- **Age and Grade** – indicate your child's age and grade. **Important Note:** Children who are age 13 or older are not eligible for dependent care reimbursement. Educational expenses for children in Kindergarten and up are not eligible; however, before and after school care is reimbursable.
- **Service Provider** – indicate the name and address of the care provider.
- **Service Date** – enter the beginning and ending dates for which the dependent care was **provided**, not the date you were charged for the services or that you paid for the service. Claim requests for multiple months will be prorated and itemized based on the number of months listed.
- **Amount of Reimbursement** – indicate the amount of the dependent care costs that you are submitting for reimbursement.
- **Total this Page** – total all entries in the 'Amount of Reimbursement' column.
- **Grand Total for Multiple Pages** – add the 'Total this Page' box together for all pages if you are submitting more than one page of claims. Enter the grand total in this box. **Note:** Make sure you complete the 'Page ___ of ___' at the top of the claim form.
- **Signature of Daycare Provider** – if your daycare provider signed this section, no further documentation is needed.