



PeopleFirst

PLAN YEAR _____

FLEXIBLE SPENDING ACCOUNT • REIMBURSEMENT REQUEST FORM

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.
PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF THIS FORM

A. NAME _____ **HOME PHONE** () _____ **DAY PHONE** () _____
ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____
SOCIAL SECURITY NO. _____ **EMPLOYER** _____

B. MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT						
SUMMARY OF EXPENSES				DATES SERVICE PROVIDED		
Name of Person Receiving Service	Relationship to Employee	Provider of Services (Ex.: Hospital, Doctor/Dentist, Drugstore, Medical Supply Store)	Co-Pay	From Mo/Day/Yr	To Mo/Day/Yr	Amount to Be Reimbursed
TOTAL						

C. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT						
SUMMARY OF EXPENSES				DATES SERVICE PROVIDED		
Name of Person Receiving Service	Relationship to Employee	Age and Grade	Name and Address of Person or Facility Providing Dependent Care Services	From Mo/Day/Yr	To Mo/Day/Yr	Amount to Be Reimbursed
TOTAL						

SIGNATURE OF DAY CARE PROVIDER LISTED ABOVE: _____

Separate receipts are not required if your dependent care provider signs this form after you have completed and signed it. Separate receipts must be attached to this form if your dependent care provider does not sign this form.

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 FSA plan(s), provided to me and my IRS-eligible dependents, on the date(s) indicated above as being incurred within my period of coverage during the 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 will collect and maintain sufficient documentation to validate my reimbursed FSA expenses.
- I will not claim any reimbursed FSA expense for any federal income tax deduction or credit.
- I specifically release my Employer and PeopleFirst from any liability resulting from either my participation in any FSA or for any misrepresentation I make regarding my requests for reimbursement.
- If I participate in my Employer's Dependent Care 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. My spouse is considered working (i.e., gainfully employed) if he or she is a full-time student for five months during the calendar year at an educational organization, or is physically or mentally incapable of self-care.
- I have read and understand the information on the front and back of this form.

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

PARTICIPANT'S SIGNATURE: _____ **DATE:** _____

INSTRUCTIONS FOR REIMBURSEMENT ACCOUNT

(To assure the quickest turnaround and best service, please read these instructions carefully.)

General Reimbursement Request Instructions

- Contact People First Service Center at: <https://peoplefirst.myflorida.com>, or call 1-866-ONE-HRFL (1-866-663-4735); TTY (1-866-221-0269) (toll-free) to request information or assistance.
- Reimbursement Request Forms will be returned unprocessed if the instructions on this form are not followed.
- To request reimbursement of an eligible expense, supporting documentation is required with your reimbursement request and described further in the instructions under each section below.
- You must maintain copies of the information and documentation you submit for all reimbursed expenses to respond to any IRS inquiries you may receive.
- Cancelled checks and charge receipts (or copies) are not acceptable receipts by the IRS to support the reimbursement of expenses.
- You may not request reimbursement until services have been provided, regardless of when you paid for the service.
- IRS regulations provide that any unused funds that remain in an account after a plan year ends (and all reimbursable requests have been submitted and processed) cannot be returned to you nor carried forward to the next plan year but will be forfeited to your Employer.
- If dates of provided services begin in one plan year and end in the next plan year, and you are enrolled in both plan years, you must submit a separate Reimbursement Request Form for each plan year in which the services were provided.
- Your supporting documentation must be legible.
- You must read over your Reimbursement Request Form to ensure that you have signed, dated and completed it, and attached any required supporting documentation.
- You may access your personal information or request Reimbursement Request Forms, 24 hours each day, by calling People First's Information Line at 1-866-ONE-HRFL (1-866-663-4735); TTY (1-866-221-0269).

Additional Medical Reimbursement Account Request Instructions

- Make sure you complete Section B in its entirety.
- To request reimbursement of an eligible medical expense, the following minimum supporting documentation is required: a copy of a receipt, invoice or bill from the provider showing the date service(s) were received, the cost of the service(s), the type of service(s) incurred, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
- Caution: IRS Pub. 502 is intended to help you decide what expenses are deductible on Schedule A to IRS Form 1040. No portion of IRS Pub. 502 should be relied upon to help you decide what expenses are reimbursable under a medical plan.
- The IRS requires the complete name of all drugs be obtained and documented on pharmacy receipts.
- If the medical coverage is not provided through an HMO, you must attach an Explanation of Benefits (EOB) from the health insurance provider showing the date service(s) were received, the cost of the service(s), the type of medically necessary service(s) received, the name of the IRS-eligible person(s) for whom the service(s) were provided, and any uninsured portion of the cost.
- Some capital expenditures may qualify as medical care under IRC § 213. General rules for capital expenditures that could be reimbursable are: (i) a special version of an otherwise personal item can be reimbursed to the extent of the increased cost; (ii) an item permanently attached to a dwelling can only be reimbursed to the extent that its cost exceeds the increase in value; (iii) if there is no personal element and the item is not attached to a dwelling, it must only be used by the person for whom the medical need has been determined; but (iv) if the item is used by others as well, only a prorated amount of the entire cost can be reimbursed.
- Reimbursement of the cost of certain capital expenditures may require (i) a Letter of Medical Need from the treating healthcare provider, (ii) a Personal Use Statement signed by the participant, and (iii) a Capital Expenditure Worksheet.
- Some provided medical treatments and services, including those that could be deemed personal or cosmetic, require a Letter of Medical Need from the treating healthcare provider.
- The standard mileage rate reimbursable for use of an automobile to obtain medical care is subject to annual IRS changes.

Additional Dependent Care Reimbursement Account Request Instructions

- Make sure you complete Section C in its entirety.
- To request reimbursement of an eligible dependent care expense, you must submit a copy of a receipt, invoice or bill from the provider showing the name and address of the provider showing the beginning and ending dates of the provided services, the cost of the service(s), the age and grade, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
- Dependent care expenses must be provided to allow you and your spouse (if married) to work or actively look for work. Your spouse is considered working (i.e., gainfully employed) if, among other requirements, he or she is a full-time student at an educational organization, or physically or mentally incapable of self-care.
- Reimbursement can only be made for eligible expenses incurred for the dependent care of one or more qualifying individuals who reside in your household, at least eight hours a day.
- A qualified person is your tax dependent age 12 or younger, or your spouse or tax dependent who is physically or mentally incapable of self-care.
- People First is unable to issue payment on approved reimbursement requests until after the last date of service for which you are requesting reimbursement.
- For timely processing of your request, your payroll contributions must be current.
- The amount of reimbursement requested on this form, added to the dependent care expenses reimbursed to date from any other source or plan, cannot exceed the statutory limits based upon your tax filing status.
- Payments for dependent care cannot be made to you, your spouse, or someone you or your spouse claim as a tax dependent.
- Educational expenses incurred for a child in kindergarten and up are not reimbursable. The cost of dependent care before and after school is reimbursable.
- Tuition is not a reimbursable expense.
- Expenses such as registration fees, activity fees, books, supplies and meals are not reimbursable.

Mail to:

**People First Service Center
Flexible Spending Account
Post Office Box 1800
Tallahassee, FL 32302-1800**

**Customer Service: (1-866-ONE HRFL); TTY: (1-866-321-0269)
TOLL FREE FAX: (888)800-5217 LOCAL FAX (850) 425-4608**

**If you fax your reimbursement request to People First, retain a copy for your records.
Do not mail the copy of your faxed transmittal to People First.**