



Flexible Spending Account Request for Reimbursement

Instructions:

- If you are submitting expenses for more than one calendar year, you must submit a separate form for each year.
- Complete all information and be sure to sign the certification statement at the bottom of the form.
- Keep copies of all documentation for your own records.
- Send your request for reimbursement to: POMCO Group, Inc., 2425 James Street, Suite A, Syracuse, NY 13206

Part 1: EMPLOYEE INFORMATION

Name: Last	First	Social Security Number
Mailing Address: Street/PO Box	City	State Zip Code
Have you moved since your last request for disbursement? Yes No If YES, is this your new address? Yes No		

Part 2: DEPENDENT CARE EXPENSE ACCOUNT

IMPORTANT: ATTACHED RECEIPTS MUST INCLUDE PROVIDER'S NAME AND ADDRESS, FEDERAL TAX I.D. OR SOCIAL SECURITY NUMBER, DATE OF SERVICE AND DESCRIPTION OF SERVICES.

DEPENDENT'S NAME/AGE	RELATIONSHIP	DATES OF SERVICE FROM - TO	PROVIDER OF SERVICE	TYPE OF SERVICE	REIMBURSEMENT REQUEST
Total Reimbursement Request:					

Part 3: UN-REIMBURSED MEDICAL/DENTAL EXPENSE ACCOUNT

IMPORTANT: SEE REVERSE SIDE FOR PROPER DOCUMENTATION WHEN SUBMITTING REIMBURSEMENT REQUESTS.

PATIENT'S NAME/AGE	RELATIONSHIP	DATES OF SERVICE FROM - TO	PROVIDER OF SERVICE	TYPE OF SERVICE	REIMBURSEMENT REQUEST
Total Reimbursement Request:					

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses listed above meet all of the Internal Revenue Code requirements and were incurred by me (and/or dependent), were not reimbursed by and any other plan, and, to my knowledge, are eligible for reimbursement under my FSA. I am solely responsible for any tax reporting and other legal requirements with respect to reimbursable expenses. I also understand that expenses for which I am reimbursed through a Flexible Spending Account may not be claimed as expenses for purposes or credit against Federal Income Tax. I accept sole responsibility for proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

Employee Signature _____

Date _____

Dependent Care Expenses Documentation

Eligible dependents include:

- . Children under 13 years of age
- . Disabled children
- . Disabled parents
- . Disabled spouse
- . Other relatives qualifying under the Internal Revenue Code

If the employee is married, in addition to working while the dependent is being cared for, the employee's spouse must be:

- . A wage earner
- . A full-time student for at least five months of the year, or
- . Disabled or unable to provide for his or her own care

Dependent Care Expenses to be reimbursed through the Flexible Spending Account cannot exceed the lesser of your income or that of your spouse.

Covered expenses include payments for:

- . Licensed nursery schools and day care centers for pre-school children
- . Housekeepers, cooks, or maids providing dependent care in the employee's home, including the cost of food and lodging
- . Individuals (other than employee's dependents) who provide dependent care for the employee's children, in or outside of the employee's home

Medical Expenses Documentation

Each expense you submit for reimbursement must be properly documented.

Acceptable forms of documentation include Explanation of Benefits (E.O.B.'s) from insurance companies, and bills from providers of service.

A bill from a provider must be on the provider's letterhead or billing form, and must include the following information:

- . Name of patient
- . Date of billing
- . Date of Service
- . Description of service
- . Amount charged for service

Bills for prescription drugs and eligible equipment, appliances or supplies must include the above information, and must also indicate the following:

- . Description of item
- . Prescription number
- . Name of prescribing physician
- . Date of purchase or rental date range

Only EOB's and itemized bills will be accepted.

"Balance Forward", "Amount Due" or similar wording, are not acceptable statements. Cancelled checks are also not acceptable.