LANSING COMMUNITY COLLEGE

Flexible Spending Accounts Claim Form

 NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent Care Flexible Spending**

Dependent care expenses must be for a dependent incapable of self care or under the age of13 at the time the care was provided.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Dependent | age | Dates Care Provided | Name and Address of Care Provider | Cost for Care Period |
| From | To**\*** |
|  |  |  |  |  |  |
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|  |
|  | **Total Dependent Care Amount Requested** |  |

I provided the dependent care as stated above. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Care Provider's **original** signature Date

\*Signature from care provider can be used in place of receipt but is not required if receipt is submitted.

## **Medical Flexible Spending**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date Service Provided\* | Name of Provider | Description of Services  | Patient Name  | Relation-ship | Amount  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
|  |  **Total Amount Requested** |  |

Please arrange documentation in order listed above**.**

\***Claims for future services will not be accepted**.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

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Employee's Signature Date

 General Agency Company

**EMAIL FORM ALONG WITH** 525 East Broadway

**SUPPORTING DOCUMENTATION TO** Mt. Pleasant, MI 48858

 benefits@ga-ins.com (email)

 989-773-6981 (phone)

 989-772-1855 (fax)

# **Claim Filing Requirements**

1. ***Print your name***
2. ***List expenses by date & arrange the supporting statements in the same order.*** Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
3. ***Enclose required documentation***.A written statement from the Dental/Vision provider of the service or an insurance company benefits statement showing all of the following:
* The name of the provider,
* The date or range of dates of services. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
* A description of the service provided (for example "dental cleaning", or “vision exam co-pay”)
* The name of the person or persons receiving the services, and
* The cost of the service, not just the amount paid.

 Requests filed without the above documentation cannot be processed and will be returned.

1. ***Sign*** the claim form.
2. ***Keep*** copies for your tax records.
3. ***Mail, fax or email*** to the address on the front of this form.

***Orthodontics:*** Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.