FLEXIBLE SPENDING ACCOUNT
DEPENDENT CARE EXPENSE CLAIM FORM

FAX TO: 303-221-2785
IT IS NOT NECESSARY TO INCLUDE A COVER SHEET

PLAN & EMPLOYEE INFORMATION

☐ Check here if you have an address change

FIRST NAME: ______________ LAST NAME: ______________ SOCIAL SECURITY NUMBER: ______________

ADDRESS: ______________ CITY: ______________ STATE: ______ ZIP: ______

DAYTIME PHONE: ______________ E-MAIL[1]: ______________ DATE OF BIRTH: ____/____/____

EMPLOYER NAME: ______________ PLAN YEAR: ______________

DEPENDENT CARE EXPENSES

*******PLEASE DO NOT HIGHLIGHT ITEMS ON THIS FORM IF YOU WILL BE FAXING*******

PROVIDER NAME	* PROVIDER TAX ID #	PROVIDER ADDRESS, CITY, STATE & ZIP	START DATE	END DATE	NAME OF DEPENDENT	AMOUNT
					TOTAL EXPENSES	

**** Your claim cannot be paid without a Provider Tax ID Number or Provider Social Security Number***

If your employer has adopted the grace period (IRB 2005-42), expenses incurred during that period (typically 75 days after the plan year ends) are eligible for reimbursement from either the current or the previous FSA plan year. If you are seeking reimbursement for expenses incurred within that period, please mark one of the boxes below to indicate the plan year from which you would like to be reimbursed. If you do not mark one of the boxes, the previous plan year's balance will be exhausted.

☐ Reimburse from previous plan year ☐ Reimburse from current plan year

REIMBURSEMENT INFORMATION

Planned Benefit Systems, Inc. will process your reimbursement according to the banking method we currently have on file, either check or direct deposit*. If you would like to make a change, you must submit a completed Reimbursement Authorization Agreement, which can be found on the forms page of our website at www.pbs.us.com, click on *Tax-Advantaged Plan Administration* and then *Forms* under the Participants list. Your reimbursement method will remain in effect until an updated authorization form has been received and processed by PBS. To ensure your claim is paid using the method of your choice, it is advisable to submit changes well before submitting a request for reimbursement.

Direct deposits normally take 2 business days from the date of initiation. Bank holidays/weekends may affect when the deposit is credited to your account. Please contact your bank to verify all deposits are received. If you provide us with your email address we will inform you each time a Direct Deposit is initiated. Direct Deposits cannot be posted to debit or credit cards. Any direct deposit remitted by Planned Benefit Systems, Inc. and not rejected by your bank is deemed a valid reimbursement and will not be adjusted. There may be a $25 fee to reissue lost/stolen checks.

*Direct deposit is not offered as an option under all plans. If your plan does not offer direct deposit, a check will always be issued for your reimbursements.

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these dependent care expenses have not already been reimbursed under this plan or any other plan and will not be reimbursed under any other employer plans or coverage. I certify that these dependent care expenses were incurred for my eligible dependents and have not been paid to anyone who is my child or stepchild under the age of 19 and claimed as a dependent on my income tax return. **I understand that I am responsible for acquiring and retaining receipts from my provider for services claimed under this plan. I further understand that I am responsible for reporting the Tax ID# provided above on IRS Form 2441 when I file my federal income taxes.** I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand.

PLANNED BENEFIT SYSTEMS CANNOT PROCESS THIS CLAIM WITHOUT A SIGNATURE BELOW

SIGNATURE: ______________________________ DATE: ______________________

Planned Benefit Systems, Inc. • www.pbs.us.com
P.O. Box 4594, Greenwood Village, CO 80155-4594
Customer Service 800-800-0133 Local 303-221-2783
Fax 303-221-2785

HOW TO FILE YOUR CLAIM

COMPLETE AND SIGN YOUR CLAIM FORM AND REMIT TO PBS IN ONE OF THE FOLLOWING WAYS:

FAX: **303-221-2785**

MAIL: **PLANNED BENEFIT SYSTEMS, INC.**
P.O. Box 4594
Greenwood Village, CO 80155-4594

EMAIL: pbsclaims@pbs.us.com

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

THINGS TO REMEMBER ABOUT DEPENDENT CARE REIMBURSEMENTS

- A Caregiver Tax ID Number or Social Security Number must be provided in order to have your claim processed. According to IRS guidelines, it is your responsibility to acquire and retain Provider Receipts.
- The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse.
- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your income tax return.
- An eligible dependent is someone who spends at least 8 hours a day in your home and is one of the following:
  - A child under the age of 13 for whom you can claim as an exemption for income tax purposes.
  - A dependent under the age of 13 for whom you have custody for more than half of the year if you are divorced or legally separated.
  - A dependent that is physically or mentally incapable of self-care (regardless of age).
  - Your spouse who is physically or mentally incapable of self-care.
- Extended overnight summer camps, private Kindergarten and higher-grade tuition, non-work related babysitting expenses and long term care services ARE NOT eligible expenses. The only expenses that are considered eligible under the Dependent Care FSA are those that are incurred while you or your spouse are working, looking for work, or attending school full time.

[1] **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, help@pbs.us.com, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at www.pbs.us.com. Select *Tax-Advantaged Plan Administration,* then *Account Information* under the Participants section and then log in under *Participant Login.* PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.

FLEXIBLE SPENDING ACCOUNT
HEALTH CARE EXPENSE CLAIM FORM

FAX TO: 303-221-2785
IT IS NOT NECESSARY TO INCLUDE A COVER SHEET

PLAN & EMPLOYEE INFORMATION

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FIRST NAME: ____________ LAST NAME: ____________ SOCIAL SECURITY NUMBER: ____________

ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ______

DAYTIME PHONE: ____________ E-MAIL*: ____________ DATE OF BIRTH: ____/____/____

EMPLOYER NAME: ____________ PLAN YEAR: ____________

HEALTH CARE EXPENSES

*****PLEASE DO NOT INCLUDE PBS BENEFITS CARD TRANSACTIONS ON THIS FORM*****
*****PLEASE DO NOT HIGHLIGHT RECEIPTS OR ITEMS ON THIS FORM IF YOU WILL BE FAXING*****

SERVICE START DATE	SERVICE END DATE	SERVICE PROVIDER	SERVICE DESCRIPTION	WHO INCURRED EXPENSE	AMOUNT
				TOTAL EXPENSES	

If your employer has adopted the grace period (IRB 2005-42), expenses incurred during that period (typically 75 days after the plan year ends) are eligible for reimbursement from either the current or the previous FSA plan year. If you are seeking reimbursement for expenses incurred within that period, please mark one of the boxes below to indicate the plan year from which you would like to be reimbursed. If you do not mark one of the boxes, the previous plan year's balance will be exhausted.

☐ Reimburse from previous plan year ☐ Reimburse from current plan year

REIMBURSEMENT INFORMATION

Planned Benefit Systems, Inc. will process your reimbursement according to the banking method we currently have on file, either check or direct deposit*. If you would like to make a change, you must submit a completed Reimbursement Authorization Agreement, which can be found on the forms page of our website at www.pbs.us.com, click on *Tax-Advantaged Plan Administration* and then *Forms* under the Participants list. Your reimbursement method will remain in effect until an updated authorization form has been received and processed by PBS. To ensure your claim is paid using the method of your choice, it is advisable to submit changes well before submitting a request for reimbursement.

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*Direct deposit is not offered as an option under all plans. If your plan does not offer direct deposit, a check will always be issued for your reimbursements.

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these expenses will not be claimed again when filing IRS form 1040 and that they were incurred for me or my eligible dependents. I certify that these health care expenses have not already been reimbursed under this plan or any other plan and are not reimbursable under any other coverage or employer plans. I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand. I further certify that the over-the-counter expenses claimed above are to alleviate or treat injuries or illnesses and will not be used for cosmetic purposes or for general good health.

PLANNED BENEFIT SYSTEMS CANNOT PROCESS THIS CLAIM WITHOUT A SIGNATURE BELOW

SIGNATURE: ____________________ DATE: ____________________

Planned Benefit Systems, Inc. • www.pbs.us.com
P.O. Box 4594, Greenwood Village, CO 80155-4594
Customer Service 800-800-0133 Local 303-221-2783
Fax 303-221-2785

HOW TO FILE YOUR CLAIM

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FAX: **303-221-2785**

MAIL: **PLANNED BENEFIT SYSTEMS, INC.**
P.O. BOX 4594
GREENWOOD VILLAGE, CO 80155-4594

EMAIL: pbsclaims@pbs.us.com

PLEASE KEEP A COPY OF THIS FORM AND YOUR ORIGINAL RECEIPTS FOR YOUR RECORDS.

TIPS FOR FILING YOUR HEALTH CARE CLAIMS

Submit your provider receipt(s) or an Explanation of Benefits (EOB) from your insurance company that includes the following information:

- ✓ Name of Service Provider
- ✓ Who incurred the expense
- ✓ Date of Service(s)
- ✓ Cost of Service
- ✓ Description of Service

Cancelled checks, credit card receipts or statements that only show a "Balance Due" are not acceptable forms of substantiation. The best way to ensure a claim will be reimbursed is to submit your expenses to your insurance provider (if applicable), receive an Explanation of Benefits detailing what was not covered by insurance, then submit a claim form and the EOB.

THINGS TO REMEMBER ABOUT HEALTH CARE REIMBURSEMENTS

- Services must be rendered during the plan year while you're an active participant.
- If you have entered the plan mid-year or terminated participation, only expenses incurred while you were an active participant are eligible for reimbursement.
- You may be eligible to continue in the plan after termination, ONLY if you had a positive account balance at termination and elect COBRA.
- **Orthodontic** work is reimbursed as paid to the provider. **Submit your claims as you pay for the services** (i.e. submit claim for 25% down payment when paid and submit receipts for monthly installments as paid). We must have a receipt from the provider showing payment was made in the current plan year. Please do not send a copy of a payment schedule or a copy of a cancelled check, as they are not enough to substantiate the claim.
- **Cosmetic surgery/procedures ARE NOT** eligible expenses unless deemed medically necessary by a licensed physician. Planned Benefit Systems will require a Certification of Medical Necessity from your physician. **Teeth whitening/bleaching** is considered cosmetic and **IS NOT** eligible for medical reimbursement.
- For a more comprehensive list of "Eligible Medical Expenses", please visit our website at www.pbs.us.com.

[1] **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, help@pbs.us.com, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at www.pbs.us.com. Select *Tax-Advantaged Plan Administration,* then *Account Information* under the Participants section and then log in under *Participant Login.* PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.