Washington County School System
Employees Flexible Benefit Plan

Plan Year-Ending

_____
mm/dd/yy

Last Name (Please Print)	First Name	Middle Init	Social Security Number

You must provide insurance EOB's, hospital or doctor bills or other evidence from independent third parties that the Medical Expenses where incurred. You must provide bills from your dependent care provider or other evidence that the Expenses were incurred (canceled checks and/or credit card receipts will not be accepted). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you.
Please date and sign the Form, then send it along with your supporting documentation.

MEDICAL FLEXIBLE SPENDING ACCOUNT

(List each receipt separately. Use additional forms if necessary.)

	Patient's Name and Relationship to Participant (A)	Provider's Name (B)	Description of Service (C)	Dates of Service Provided (D)	Requested Amount of Reimbursement (E)
1.					
2.					
3.					
4.					
				TOTAL:	

I certify that the above expenses were for services provided during the current Plan Year. I have not been reimbursed previously for these expenses under the Medical Expense Reimbursement component of the Plan. These expenses have not been reimbursed or are not reimbursable under the major medical plan or any other health plan, such as my Spouse's plan. I also certify that these expenses are form myself, spouse or a dependent that will be named on my income tax return. A copy of a billing or receipt showing the date-of-service is required to be attached for each expense. These are reimbursable medical expenses as defined by Internal Revenue Code Section 213 and 105 , and does not include cosmetic surgeries, vitamins and/or herbals (unless prescribed for a specific medical condition), prescription drugs purchased outside of the U.S., insurance premiums or services that were not prescribed by a licensed physician or dentist. Only expenses due for the current plan year will be allowed to be reimbursed for orthodontic and maternity expenses. Prepayment for maternity or orthodontic expenses can only be reimbursed if the contract states payments are non refundable. I understand that the bill for the services performed does not have to be paid before requesting reimbursement; except for orthodontic and pre-natal care; however, the services do need to have been provided by the date of this request, unless orthodontic or pre-natal. Expenses must also occur prior to termination of employment.

Please indicate that each receipt includes:

- ☐ Date of Service (within the plan year)
- ☐ Amount of expenses
- ☐ Nature or Service defined by explanation or code
- ☐ Name of Service Provider

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

	Dependent's Name and Relationship to Participant (A)	Provider's Name (B)	Provider's ID Number (C)	Dates of Service Provided (D)	Requested Amount of Reimbursement (E)
1.					
2.					
3.					
4.					
				TOTAL:	

I certify that the above expenses were incurred during the current Plan Year and are reimbursable Dependent Care Assistant Program expenses as defined below. A billing or receipt showing the date range of services is attached for each expense. I hereby accept full responsibility for all information given my Employer in connection with this claim. I certify that none of these claims, if reimbursed, will be claimed as a deduction on my income tax returns. Any employment-related expense for household and dependent care services necessary for gainful employment is reimbursable under the Dependant Care Assistance Program. The expenses listed are for my Dependent as defined in the Plan. I have not been reimbursed previously for the expenses under the Dependent Care FSA. These expenses have not been reimbursed or are not reimbursable under any other plan. This expense must be incurred while (1) the Employee has a child under the age of `13 for which the Employee received an income tax exemption or (2) the Employee has a dependent or spouse who is physically or mentally incapable of caring for himself if the dependent spends at least eight hours each day in the taxpayer's household. In addtion, employment related expenses are allowed for services outside the taxpayer's household if incurred for the care or (1) or (2) above.

Mail or Fax to:
CPI QUALIFIED PLAN
CONSULTANTS, INC.
P.O. Box 1167
Great Bend, KS 67530-1167
Attn: Flexible Benefit Services
Fax: 620-792-3517

Participants will be responsible for any tax due for reimbursements not approved by the Internal Revenue Service.

_____ _____
Signature of Participant Date