



52040

FLEXCHOICE

Healthcare and Dependent Care Flexible Spending Account

Reimbursement Claim Form

Sentinel Benefits & FINANCIAL GROUP

Custom Solutions for Life and Wealth

EMPLOYER NAME

PLEASE PRINT CLEARLY

Employer Name input field

EMPLOYEE INFORMATION

Social Security Number

Social Security Number input field

Last Name

Last Name input field

First Name

First Name input field

Email Address

Email Address input field

Home

Home Phone

Home Phone input field

Office Phone

Office Phone input field

Office

INSTRUCTIONS

Check here if you are submitting debit card verification receipts.

IMPORTANT INFORMATION: KEEP A COPY OF THIS FORM AND RECEIPTS FOR YOUR RECORDS (Please see page 2 for additional information.)

1. Please complete the appropriate section for each account you are submitting claims (i.e. Dependent Care Account/Healthcare Account).
2. Attach the documentation in the order in which you have the expenses listed.
3. The documentation must contain the date(s) of service, expense/purchase incurred and the name of the service provider.
4. Cancelled checks and credit card receipts are not a valid form of documentation.
5. The form must be signed and dated in order to be processed and approved.
6. Please fax or mail the form with receipts to the address below.

HEALTHCARE CLAIM INFORMATION

Date of Service			Service Provider/Description of Service (i.e. co-pay, eye exam, prescription, etc.)	Amount Requested	
MM	DD	YY			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Reimbursement Requested				<input type="text"/>	<input type="text"/>

DEPENDENT CARE CLAIM INFORMATION

Please provide a statement from the Dependent Care Provider listing the following information. If no statement is provided, complete the Certification information below.

- Begin and end dates of service
- Description of charges
- Provider's signature
- Tax ID# or Social Security# of Provider

Start Date			End Date			Dependent's Name	Amount Requested	
MM	DD	YY	MM	DD	YY			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Reimbursement Requested							<input type="text"/>	<input type="text"/>

Dependent Care Provider's Certification of Services Rendered (in lieu of a printed statement from Provider)

I, the signer below, certify that the services listed above were rendered by me and the charges incurred have been paid.

Provider of Service input field

Dependent Care Provider's Company Name

Dependent Care Provider's Company Name input field

Signee's Name

Signee's Name input field

Address, City, State

Address, City, State input field

Provider's Signature

Provider's Signature input field

Tax ID (Required)

Tax ID (Required) input field

CERTIFICATION

I request payment from my reimbursement account for the expenses itemized above. I certify that I have not previously requested reimbursement under this plan or from any other source for these expenses. I also certify that the total dependent care expenses (if any) for which I am requesting this plan year do not exceed the lesser of my or my spouses earned income for the year.

I further certify that I have met all of the requirements for eligible healthcare and dependent care expenses as described on the second page of this form. I understand that reimbursement expenses cannot be claimed on my personal income tax return.

Signature

Signature input field

Date

Date input field

ADDITIONAL INFORMATION REGARDING REIMBURSEMENTS

HEALTHCARE ELIGIBLE EXPENSE INFORMATION

In general, an employee may be reimbursed for a healthcare expense which qualifies as a deduction on the federal income tax return, but which has not or will not be reimbursed by any other source and has not been or will not be deducted on the employee's income tax return. Some examples of eligible expenses include co-payments and deductible amounts, vision, hearing, dental, and prescription drug expenses not covered by your health insurance.

More information about Healthcare Expenses, including eligible over-the-counter items, are found on our website at www.sentinelgroup.com.

Required Supporting Documentation

The following supporting documentation must be attached to this form:

Expenses covered by your Healthcare plan - medical, dental and vision expenses covered by your Healthcare plans must be submitted under that plan first. Attach a copy of the Explanation of Benefits statement to claim amounts not paid by your Healthcare Plan.

For all other expenses, attach bills that clearly state:

- Date service was rendered or purchased
- Description of service or item
- Name of provider of service
- Amount charged
- Name of the person receiving the service
- Proof of Purchase

Dental Care

Receipts related to Dental claims must include a description of the service provided. Cosmetic services are not eligible for reimbursement.

DEPENDENT CARE ELIGIBLE EXPENSES

In general, the following rules apply to dependent care expenses:

- No participant shall be allowed to defer more than \$5,000, if married filing jointly, or \$2,500 if married filing separately. The maximum that can be deferred under this program shall be the lesser of \$5,000 or the earned income of the participant's spouse.
- Overnight camp and kindergarten are not eligible expenses.
- The expenses must be employment related expenses for the care of a dependent of the employee who's entitled to a dependent deduction under the Internal Revenue Code section 151(e), or a dependent who is physically or mentally incapable of caring for himself or herself.
- Payments cannot be made to a person who is claimed as a dependent by the employee.
- If the services are provided by a Dependent Care center which provides care for more than six individuals, the center must comply with state and local laws.
- Dependent Care expenses are reimbursed when payroll contributions are received and processed on our administration system.

Dependent Care Claim Checklist

1. Complete the requested information on the front of this form.
2. Have the Caregiver sign the front of this form.
3. Attach a cancelled check or receipt from the caregiver if one exists.
4. Provide the Tax ID# or Social Security Number of the Service Provider.

NOTE: DIRECT DEPOSIT IS THE QUICKEST WAY TO RECEIVE YOUR REIMBURSEMENT

Reimbursements will be faster if you have signed up for direct deposit. To request direct deposit, simply go to our website www.sentinelgroup.com, click on "customer service" and then click on "forms." Complete the FlexChoice Direct Deposit form and send it directly to Sentinel Benefits.

In an effort to provide you with faster notification of processed claims, we will send you an e-mail notification when the funds have been processed for remittance to your account.

Claims faxed in good order by 5:00 PM ET on Wednesday will be processed by Friday. (Holidays may impact this schedule.) Reimbursement checks are mailed via US Postal Service.