DIVISION OF STATE GROUP INSURANCE
FLEXIBLE SPENDING ACCOUNTS PROGRAM
REIMBURSEMENT CLAIM FORM

PART 1 PARTICIPANT INFORMATION (Please Print) *See back for general information.*

Social Security Number - -	For Plan Year	Home Phone # Office Phone # SUNCOM #		
Last Name	First Name	M.I.	Department/Agency	
Address	City	State	Zip	☐ Check here if change of address.

PART 2 UNREIMBURSED MEDICAL EXPENSES *See back for documentation information.*

	PATIENT'S NAME	DATES OF SERVICE FROM - TO		SERVICE PROVIDER / TYPE OF SERVICE	EXPENSE INCURRED	*FOR INTERNAL USE ONLY* CODE	AMOUNT
A							
B							
C							
D							
E							
2A							
2B							
2C							
2D							
2E							

PART 3 DEPENDENT DAY CARE EXPENSES
(See back for documentation information.)

Care for: children under age 13- nursery school, day care center, baby-sitter or an elderly dependent, spouse of other legal dependent who is incapable of self-care and who spends at least 8 hrs/day in your home.

	DEPENDENT'S NAME	AGE	DATES OF SERVICE FROM - TO		SERVICE PROVIDER / TYPE OF SERVICE	EXPENSE INCURRED	*FOR INTERNAL USE ONLY* CODE	AMOUNT
F								
G								
H								
I								

PART 4 PARTICIPANT'S CERTIFICATION OF REQUEST

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Day Care Expenses which I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expenses for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Day Care Expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Participant's Signature: ______________________________ **Date:** ____________________

Following each Plan Year (January 1 through December 31),
April 15 is the final deadline for filing all claims.

General Information

- You may use one form to file claims for Medical Expense and Dependent Care reimbursement accounts.
- You may file up to ten Medical and four Dependent Care expenses on one form. *Note: Attach additional forms if more space is needed.*
- **Cancelled checks, cash register receipts, or credit card receipts are not acceptable as receipt documentation.**
- You may use copies of this claim form if no originals are available.
- **You must file claims for different years on separate forms.**
- Expenses must be for dates of service rendered during the Plan Year (calendar year). *Note: Your eligible participation period may be different depending on your enrollment date, or if you terminate participation during the year.*
- Your claim form must have receipt documentation attached to it **before** it can be processed.
- Eligible expenses are based on when the services were rendered, **not** when billing or payment for services occurs.
- To **change your address**, the W-4 form in your personnel office must be changed.
- If you are reimbursed for any expense that is later paid by insurance or refunded by any means, you must report this to the address below. Your account will be adjusted.

Medical Expense Documentation

Expenses for dates of service after you terminate employment are not eligible for reimbursement unless advance arrangements have been made to continue contributions to your Medical Account.

MEDICAL SERVICES

- For services covered by insurance, you must attach statements from the insurance company indicating patient responsibility for the expense.
- For services not covered by insurance you must attach itemized receipts or bills that include: patient’s name, date of service, type of service, provider’s name and address, and the expense.

PRESCRIPTION DRUGS

- Your receipts must include patient’s name, date of service, pharmacy name and address, and the expense. *Note: The pharmacy prescription label generally contains the necessary elements for required documentation.*
- Non-prescribed or over-the-counter items are not reimbursable.

Dependent Day Care Documentation

- Your receipt must include: the provider’s name, address, tax identification number or Social Security number, a description and date(s) of service(s); the dependent’s name, dependent’s age, and an itemized statement of the expense.
- To qualify for reimbursement your child must be age 12 and under.
- To qualify for reimbursement your child or other dependent over the age of 13 must be incapable of self support and spend 8 hours or more a day in your home.
- If you make advance payments or pre-pay any fees, submit your claim for reimbursement after the service has begun.

Mail or Deliver Claims to

Division of State Group Insurance
Reimbursement Account Claims
Post Office Box 6357, 4040 Esplanade Way
Tallahassee, Florida 32314-6357

For more information, contact DSGI at **(850)921-4610 or SUNCOM 291-4610.**
This form is available at www.dsgi.state.fl.us