

**ZENITH ADMINISTRATORS INC.
FLEXIBLE SPENDING ACCOUNTS**

**CLAIM FOR DISBURSEMENT
UNREIMBURSED MEDICAL ACCOUNT**

IMPORTANT INSTRUCTIONS

Please comply with the following instructions to file your claim for reimbursement. Failure to follow these instructions will delay processing of your claim and may result in your claim being returned to you. Additional information regarding allowable expenses is provided on the reverse of this form.

1. **Complete the entire claim form, including the itemized list of expenses.** A notation of "See Attached" with documentation attached will not be accepted.
2. **Attach documentation supporting the expenses.** Acceptable documentation includes:
 - ♦ **For medical care** -- an itemized bill from the provider of service showing the date the service was performed, the provider name, the type of service and/or procedure codes, and your out-of-pocket cost for the service.
 - ♦ **For prescription drugs** -- the drug receipt or label showing the date, name of the drug, and out-of-pocket cost.
 - ♦ **For over-the-counter drugs and supplies** -- the itemized receipt from the place of purchase showing the date, item purchased, and out of pocket cost.
 - ♦ **For services covered by health insurance**, you may attach your health plan Explanation of Benefits.
3. **Note the claim line number in the upper right corner of each attachment.** For example, note "H1" in the upper right corner of your documentation for the health care expense listed first on the claim form. If one document is provided to support more than one claim line, note all applicable claim lines on the attachment.
4. **If additional space is needed for your itemization, attach a separate sheet using the same format as the itemization on the claim form.** Continue the claim line numbers on the additional sheet.
5. **Carefully read the Employee Certification on the reverse, then sign and date the claim form.**
6. **Keep a copy of this form and all supporting documentation for your records.**

Employer Name: _____

Employee Name: _____ **SSN:** _____

Employee Address: _____

| Line # note on attachments | Service Date(s) | Provider Last Name & Degree (e.g. M.D.) | Type of Service (Medical, Dental, Vision, Orthodontia, Rx) | Patient Name | Amount Requested |
|--|--------------------|--|--|-----------------|---------------------|
| H1 | | | | | |
| H2 | | | | | |
| H3 | | | | | |
| H4 | | | | | |
| H5 | | | | | |
| H6 | | | | | |
| H7 | | | | | |
| H8 | | | | | |
| H9 | | | | | |
| H10 | | | | | |
| Total Health Care Expense Claim | | | | | \$ |

EMPLOYEE CERTIFICATION OF EXPENSES AND CLAIM FOR REIMBURSEMENT

I certify that I have read and understand the Employee Certification on the reverse side of this form.

Employee Signature: _____ **Date:** _____

EMPLOYEE CERTIFICATION

Read this statement carefully then sign in the appropriate place on the front of this form.

I certify that I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for qualifying individuals. I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under any other health plan. I understand that the expense for which I am reimbursed may not be claimed as an income tax deduction. I understand that if I am reimbursed for an ineligible expense and the IRS audits my personal income tax return, I may be subjected to taxation on the reimbursement amount. I have provided sufficient documentation to support all expenses for which I am requesting reimbursement.

ELIGIBLE EXPENSES

Expenses allowed by your employer sponsored plan may vary from those permitted by the IRS. Consult your plan document to determine what expenses are allowed by your plan.

- ◆ Expenses must be incurred by you, your spouse, or eligible dependents for whom an exemption can be claimed on your tax return.
- ◆ Expenses must be incurred primarily for medical care as defined by the IRS, which includes "amounts paid for the diagnosis, cure, mitigation, treatment, prevention of disease, or for the purpose of affecting any structure or function of the body."
- ◆ Expenses for personal items are not reimbursable even if recommended by your physician. Generally, an expense is deemed "personal-only" if it would have been incurred in the absence of a medical condition. Examples are health club dues and dental hygiene products.
- ◆ Expenses for dual-purpose items, which may be personal or medical in nature, require substantiation of medical necessity. Examples are blood pressure monitors, acne medication, weight loss drugs or programs, massage therapy, and over-the-counter orthotics such as ankle or knee braces. Medical necessity can be substantiated through a letter or other documentation of illness or disease from your practitioner.
- ◆ Over-the-counter items obtained for a medical purpose are reimbursable if allowed by your plan document. Examples of OTC items with medical-only uses include allergy medications, nicotine patches or gum, thermometers, Pedialyte, and reading glasses.
- ◆ Sufficient documentation to substantiate the medical necessity of the expense must be provided in order for your claim to be processed.

You may not claim expenses which have been reimbursed or are reimbursable under any other source. If you do not comply with this requirement and the IRS audits your tax return, you will be liable for any and all back taxes due on ineligible expenses.

MAIL COMPLETED CLAIM FORM & SUPPORTING DOCUMENTATION TO:

**ZENITH ADMINISTRATORS, INC.
FLEXIBLE SPENDING ACCOUNTS DEPARTMENT
PO Box 91082
Seattle, WA 98111-9182**

FAX CLAIM FORMS & SUPPORTING DOCUMENTATION TO:

**ZENITH FSA
1-866-528-7722 or 1-206-285-4789**

**FSA CUSTOMER SERVICE PHONE:
Toll-free 1-800-757-0071 or 1-800-426-5980**