

Please read **requirements** on reverse side

Last Name, First Name, MI (Please Print)

Employee ID Number
(see your pay stub for ID number)

College Location

Street Address

City, State, Zip

Phone Number

You have until April 15th of the following year to file claims for eligible expenses incurred through the previous plan year and the grace period. After April 15th, the unspent dollars are deleted from your prior year account. **Over the counter (OTC) items, such as Rx copays, glasses, etc. require a legible receipt attached to the claim form. Medical or dental expenses require the Explanation of Benefits (EOB)** statement be attached to the claim form.** Detailed instructions are on the back of this form. See www.zenithfsaphoenix.com for more information and examples of reimbursable FSA expenses.

Dependent Care Assistance

Dependent Name & Relationship	Age	Dates Care Provided		Name, Address and Taxpayer Identification of Care Provider	Cost for Care Period
		From	To		
Total Dependent Care Amount Requested →					

I provided the dependent care as stated above.

Care Provider's Original Signature

Date

SSN/Tax ID#

Unreimbursed Health Care Expenses

Date incurred	Name of Health Care Provider	General Health Care Expense Description	Name and Relationship of Person for Whom Expense Incurred	Amount Incurred
Total Health Care Amount Requested →				

↑ Please arrange documentation in order listed above.

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud or deceive, files a statement of claim containing false, incomplete or misleading information, may be guilty of a criminal act punishable under law.

Employee Signature

Date

Mail or fax claim forms with supporting documentation to:

Zenith Administrators
2001 W. Camelback Rd, Suite B350
Phoenix, AZ 85015

Phone#: (602) 336-2241 Fax #: (602) 248-8301
(800) 553-2801 (602) 589-5376

Claim Filing Requirements

1. **Print your name, address, campus location and employee identification number**
 2. **List expenses by date & arrange the supporting statements in the same order.** Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may total them and list them on one line with a range of dates.
 - Daycare claims – complete the Dependent Care Assistance section
 - Health care claims (medical, dental, vision) – complete the Unreimbursed Health Care Benefits section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).
 3. **Enclose required documentation***. A legible statement from the dependent care or medical provider, insurance company Explanation of Benefits (EOB)** statement, pharmacy receipt or OTC receipt showing:
 - The name of the dependent care or medical service provider.
 - The date or range of dates of medical service or daycare. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
 - A description of the service provided (for example, medical, dental or vision care, eyeglasses, OTC items, Rx copays or daycare).
 - Legible proof of purchase made by you (other than the EOB for medical or dental) for the incurred expenses. Photocopies are acceptable.
- * **Dependent Care claims only** – You may either provide documentation from the daycare provider or have the provider complete the Dependent Care Assistance Section, then sign on the “Care Provider’s Signature” line and date the signature. You do not need to do both.
4. **Sign** the claim form.
 5. **Keep** copies for your tax records.
 6. **Mail** to the address or **Fax** to the fax number on the front of this form.

Requests filed without the above documentation cannot be processed and will be returned.

Dependent Care Flexible Spending Accounts: The caregiver cannot be anyone you claim as a dependent for tax purposes. Dependent care expenses must be for daycare expenses for disabled adult dependents who live in your home for at least 8 hours per day and or an eligible dependent under the age of 13 at the time the care was provided. You cannot be reimbursed for an amount in excess of the current balance in your Flexible Spending Account. Money will not be advanced to you nor can you borrow against another participant’s account. However, you may file your claim for reimbursement at the time the expenses are incurred. Reimbursement will automatically be made as deposits are made to your Flexible Spending Accounts each pay period during the Plan Year. Your total reimbursements for the Plan Year cannot exceed the total amount of the salary reductions deposited to your Flexible Spending Account.

The Dependent Care Flexible Spending Account cannot be used to pay claims for health care expenses nor can the Health Care Flexible Spending Account be used to pay dependent care expenses.

Health Care (Medical, Dental, or Vision) Flexible Spending Accounts: You may file your claim for reimbursement as soon as you receive the EOB. Medical Flex reimbursements may be made automatically following medical plan processing if you sign the applicable agreement during enrollment. Reimbursement will automatically be made up to the amount elected for the Plan Year.

Grace Period Effective Plan Year 2006 (March 15th of the following plan year): Amounts left in the health care or dependent care FSA that **remain unused after March 15th** of the following plan year (grace period) are forfeited. Unused amounts in a health care FSA cannot be used to reimburse dependent care expenses incurred during the grace period. Claims falling into the grace period will automatically apply towards prior year balances if available. Once a claim has been applied to a prior year balance, the claim allocation will not be modified.

Deadline to file prior year claims: You have until April 15th of the following year to file claims for eligible expenses incurred through the previous plan year (including the grace period). After April 15th, the unspent dollars are deleted from your prior year account.

Minimum check requirement: Minimum check amount processed from claims submitted must total at least \$50.00. Minimum check requirement is waived at the end of the plan year to close the accounts.

****Explanation of Benefits (EOB) definition:** The explanation of benefits is a statement mailed to you by your medical and/or dental insurance administrator. An EOB shows the services billed, whether the services are covered, and how deductibles, copayments, coinsurance or benefit maximums were applied. After your claim is filed and processed, you will receive an EOB. Save the EOB for your personal records and for submitting claims to your health care flexible spending account.