GIC FSA Reimbursement Request Form

benefit strategies LLC

Live Chat: benstrat.com/gic-fsa
Phone: 877-353-9442
Fax: 603-232-8079
Email: commonwealth@benstrat.com
Address: PO Box 1300, Manchester, NH 03105

Employee Information

Employee Name:
First and Last

Last 4 Digits of SSN: ☐☐☐☐

Primary Phone: ( )

Agency Name:

Email:

Agency Number:

E-mail is required to receive important account notifications

Read Carefully: Fill out form completely, including signature, and fax or mail to Benefit Strategies at the address listed above. Incomplete and unsigned claims will be returned. Please limit the number of pages faxed to a maximum of 15 pages. Reimbursement requests should be for a minimum of $25 (unless your account has less than a $25 balance). Please retain copies of what you send and retain proof of sending. Notifications will be sent via e-mail for claim confirmation, payment notification and denial letters. Payments will be sent to address on record. Claims will be applied to the earliest eligible plan year.

Health Care Reimbursement Expenses

Amount	Service Date(s)	Provider	Expense Type	Patient's Name
$				
$				
$				

$ ← Total Health Care Reimbursement Expenses Requested

Please attach any necessary documentation to substantiate your claimed expenses (see p. 2 for more information).

Dependent Care Reimbursement Expenses

Amount	Age	Dependent's Name	Name & Address of Provider	Service Date(s)
$				
$				
$				

$ ← Total Dependent Care Reimbursement Expenses Requested

Please attach receipts OR have your provider complete the Dependent Care Provider Certification below.

Dependent Care Provider Certification: Provider must certify that they have provided and been paid for the above services.

Provider Name:

Provider Signature:

Date:

Read Carefully: The undersigned plan participant certifies that all requested reimbursement expenses claimed on this form were incurred during the participant's GIC FSA coverage period and that the expenses are not reimbursable from any other source. The undersigned understands that he or she is solely responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that if a claimed expense is not reimbursable, the undersigned may be liable for payment of all related taxes, including federal, state, or city income tax on reimbursable amounts paid from the Plan with relation to such expense. I attest that I have read and understand the FSA 2020 Handbook and attest that I have followed all the plan rules and IRS rules.

Employee Signature:
Required

Date:

Print and Sign →

Health Care Reimbursement Expenses Filing Instructions

Who is eligible?

A plan participant, and their legal spouse or tax dependent .

Examples of qualifying expenses

Medical, prescription, dental, vision, and hearing expenses not covered by insurance.

Documentation must show

A. The date the expense was incurred (not the date paid)
B. The name of the service provider
C. A description of the service and/or expense
D. The amount for which you are responsible
E. Name of person receiving services

Be sure to attach a copy of the itemized receipt(s) (not the credit card receipt), or if you have insurance, please send the Explanation of Benefits Statement. Keep original receipts for your tax records , along with a copy of the completed and signed claim form and any attached documentation. Obtain and keep proof of sending in case the documents are lost in transit or transmission is unsuccessful.

Please Note:

Canceled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation

Dependent Care Reimbursement Expenses Filing Instructions

Who is eligible?

A "qualifying child or dependent" is someone whose principal place of abode is with you, and who is under age 13, or physically/mentally incapable of caring for him/herself and doesn't have income in excess of IRS tax code rules. Contact your tax or legal professional if you have questions regarding the definition of "dependent".

Examples of qualifying expenses

Preschool or daycare expenses, before and after school programs, day camp, or care of disabled dependents.

Documentation must show

A. The date the services were provided (not the date paid)
B. The name of the service provider
C. A description of the service
D. The amount for which you are responsible
E. Name and age of dependent receiving services

* Please Note: The service provider may sign the line on the claim form in lieu of a receipt.

Please Note:

Canceled checks, credit card slips, bank statements or statements showing only a balance forward are not accepted as valid receipts.

Additional Information

- The Dependent Care account is not pre-funded. Therefore, you must have sufficient funds in your Dependent Care account to cover the payment amount you are requesting.
- Expenses must be incurred on or after your effective date for the plan year and before the end of the plan year (or grace period, if adopted by the employer). In accordance with Internal Revenue Service (IRS) rules, reimbursements will not be made until the services have been provided and you cannot submit a reimbursement claim until after the services are provided.
- You are encouraged to consult your tax or legal professional to understand the requirements of participating in the Dependent Care FSA (DCAP) and the impacts it may have on your taxes. Funds reimburse through the DCAP may impact your ability to claim a federal Dependent Care Credit on your tax returns. Also, the IRS has rules about family members as providers and you need to ensure that the expenses you are paying are eligible for reimbursement.