



FLEXIBLE SPENDING ACCOUNT CLAIM FORM

PLAN & EMPLOYEE INFORMATION

Check here if you have a new address or name change.

FIRST NAME: _____ LAST NAME: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER NAME: _____ PLAN YEAR: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAYTIME PHONE: _____ E-MAIL: _____ DATE OF BIRTH: ____/____/____

HEALTH CARE EXPENSE CLAIMS

*****PLEASE DO NOT INCLUDE MBI BENEFITS CARD PURCHASES ON THIS FORM*****

SERVICE DATES	SERVICE PROVIDER	SERVICE DESCRIPTION	WHO INCURRED EXPENSE	AMOUNT
HEALTH CARE TOTAL				

DEPENDENT CARE EXPENSE CLAIMS

NAME OF DEPENDENT(S)	PERIOD COVERED	NAME, ADDRESS & TAX ID# OF PROVIDER	AMOUNT
DAY CARE TOTAL			

Provider's Certification / Verification:

I certify that the person(s) named above incurred the Day Care expenses described above and that only qualified expenses are claimed. (Day Care receipts are not required with your Provider's Certification / Verification signed below.)

Signature of Owner / Representative of the Business / Provider Address _____

Date _____

Note: The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. The service provider cannot be your dependent for federal income tax purposes, or your child / stepchild who is under age 19.

REIMBURSEMENT INFORMATION

Please issue me a Direct Deposit for this claim. My account information is already on file with PBS. Please issue me a check for this claim.

Please set me up and issue a Direct Deposit for this claim. I (we) hereby authorize Planned Benefit Systems, Inc., hereinafter called PBS, to initiate credit entries to my (our) account indicated below at the depository financial institution named below and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until PBS has received written notification from me (or either of us) of its termination in such time and in such manner as to afford PBS and DEPOSITORY a reasonable opportunity to act on it. ³

ACCOUNT NUMBER: _____

ROUTING NUMBER: _____ (NINE DIGITS)

BANK NAME: _____

CHECKING ACCOUNT

SAVINGS ACCOUNT

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the Plan. I certify that these expenses will not be claimed again when filing IRS form 1040. I certify that these expenses were incurred for eligible dependents. I certify that these health care and day care expenses have not been reimbursed and are not reimbursable under any other coverage or employer plans. With regard to day care expenses, I certify that I will include the name, address and taxpayer ID number of the service provider on my income tax return. I certify that day care expenses have not been paid to anyone who is my child or stepchild under the age of 19 and claimed as a dependent on my income tax return. I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualifying Expenses, I will indemnify and reimburse the employer that liability on demand. I further certify that the over-the-counter expenses are to treat or reduce symptoms for personal injuries or sickness and are not merely for purposes to good health.

PARTICIPANT SIGNATURE: _____

DATE: _____

FAX CLAIMS TO: 303.221.2785

PBS, Inc. 6568 S. Racine Circle #200 Centennial, CO 80111 • Customer Service 800.800.0133

HOW TO FILE YOUR REIMBURSEMENT CLAIM

PLEASE COMPLETE CLAIM FORM IN ITS ENTIRETY AND REMIT ALONG WITH RECEIPTS TO PBS ONE OF THE FOLLOWING WAYS:

FAX: 303-221-2785

MAIL: PLANNED BENEFIT SYSTEMS, INC.
6568 S. Racine Circle-Suite 200
Centennial, CO 80111

EMAIL: pbsclaims@cci-pbs.com

TIPS FOR FILING YOUR HEALTH CARE REIMBURSEMENT CLAIM

Submit your provider receipt(s) or explanation of benefits (EOB) from your insurance company with all of the following information:

- ✓ Name of Service Provider
- ✓ Address of Service Provider
- ✓ Date of Service(s)
- ✓ Cost of Service
- ✓ Description of Service

Orthodontic work is reimbursed as paid to the provider. **Submit your claims as you pay for the services** (i.e. submit claim for 25% down payment when paid and submit receipts for monthly installments as paid). We must have a receipt from the provider showing payment was made in the current plan year. Please do not send a copy of a payment schedule or a copy of a cancelled check - they are not enough to substantiate the claim.

Cosmetic surgery/procedures **ARE NOT** eligible expenses unless deemed medically necessary. Planned Benefit Systems will require a letter from a physician stating the medical necessity of any cosmetic related surgery/procedure. **Teeth whitening/bleaching** is considered cosmetic and **IS NOT** eligible for medical reimbursement. **For a complete list of "Eligible Medical Expenses" per IRS guidelines, please visit our website at www.cci-pbs.com.**

PLEASE NOTE: Services must be rendered during the plan year while you're an active participant. If you have entered the plan mid-year or terminated participation, only expenses incurred as an active participant are eligible for reimbursement. You may be eligible to continue in the plan after termination, **ONLY** if you had a positive account balance at termination. Balances will be reimbursed for daycare expenses incurred through the end of your plan year.

TIPS FOR FILING YOUR DEPENDENT CARE REIMBURSEMENT CLAIM

Dependent care claims must include a tax identification number or social security number of your provider and meet the following criteria:

- ✓ **Your dependent must be under age 13**, unless disabled, and the care must be to allow you and your spouse (if married) to go to work.
- ✓ **Overnight camps or extended summer camps** (overnight) **ARE NOT** eligible expenses. Only the cost to care for a dependent while you and your spouse are at work is an eligible expense.
- ✓ **The daycare provider must be over age 19**, if the care is being provided by a family member.

Claims will be returned within 7 days of receipt if it does not contain all of the above information. Cancelled checks, credit card receipts or receipts that only show a "Balance Due" will not be reimbursed and will be returned. The best way to ensure a claim will be reimbursed is to submit your expenses to your insurance provider (if applicable), receive an Explanation of Benefits detailing what was not covered by insurance, then submit a claim form and the EOB to PBS.

¹ **E-Mail:** By providing your e-mail address you agree to receive FSA correspondence via e-mail. E-mail regarding your FSA plan(s) will be sent from help@cci-pbs.com; please add this e-mail address to your e-mail address book to ensure receipt of all correspondence. You can change/delete your e-mail address by logging on to www.mbicard.com or by contacting the PBS, Inc. Customer Service Department. PBS, Inc. reserves the right to utilize an e-mail address that may be provided to us by your employer. PBS, Inc. will not share e-mail information with ANY outside source.

Planned Benefit Systems, Inc. www.cci-pbs.com
6568 S. Racine Circle #200 Centennial CO 80111 • Phone 800.800.0133 / Fax 303.221.2785