

Flexible Spending Plan

How to file a claim for Reimbursement of Medical, Dental and Vision Claims:

To file for Reimbursement of Medical, Dental, Vision unreimbursed expenses, you must submit an FSA Claim Form with a copy of the Explanation of Benefit Worksheet from the insurance company, or the **Original** RX receipts showing the co-pay.

Over-the-Counter drugs can be reimbursed to you also. In order for us to reimburse you for those items, we need the original receipt from the grocery store, drug store, etc. The FSA Plan can cover antacids, allergy medicine, pain relievers, cold medicine, etc.

Expenses **NOT** allowed are vitamins, toiletries, cosmetics.

If you want to know if a medicine or item is covered, you can go to www.drugstore.com and select the FSA Store or you can call our office.

*Please keep in mind that all incurred medical/dental/vision expenses which are covered by the insurance you carry, **MUST** be submitted to the insurance carrier for consideration before being submitted for reimbursement under the FSA Plan, even if your deductible has not been satisfied.*

How to file a claim for Reimbursement of Dependent Care Expenses

To file a claim for reimbursement of Dependent Care Expenses, complete the FSA Reimbursement Form. Attach a receipt from the care giver that shows their **name, address, tax ID number (Employer ID Number or Social Security Number) dates of service, charges and your payments.**

Keep in mind that we can only reimburse for dependent care up to the total amount that is deducted from your salary as of the date of your request.

Remember, Dependent Care reimbursement can only be made if the child care is due to you being a single parent, you have a working spouse, your spouse is a

full-time student for at least 5 months during the year while you are working, or your spouse is disabled and unable to provide for his or her own care.

Dependent care does not include baby-sitting expenses when you go out to dinner or just need a break. Also, the caregiver must declare the income on their income taxes.

**Mail claims to:
J. N. Morcos & Company
P O Box 98
Aurora, IL 60507**

**Any questions call us at 630-892-3900
or you can email – Jolene@morcosins.com.**

**FSA claims will be processed once a month. Any claims received
by the 20th of each month, will be processed within the
following week.**

Always keep a copy of all receipts and claims mailed to us.

Flexible Benefit Plan Reimbursement Claim Form

Employer:

Identification Number:

Employee Name:

Phone:

E-mail:

Dependent Care Expense Claim

Name of Dependents	Period Covered		Name, Address and Taxpayer Identification Number of Service Provider	Amount Incurred
	From	To		
*Attach a receipt from your daycare provider, or include the provider's signature.			Provider's Signature:	
			Total Dependent Care Expense Claim*	\$

*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. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, or \$400 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred (Mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.			Total Medical Care Expense Claim	\$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

Employer's Signature

Date

You may copy this form if additional claim forms are needed.

FAX: 1-630-892-1085 or mail to;
J. N. Morcos & Company
P. O. Box 98
Aurora, IL 60507