Flexible Spending Plan Reimbursement Voucher

Please read the back of this form for instructions on how to complete this voucher

EMPLOYER / GROUP NAME

YOUR NAME **S.S. NUMBER (Last 4 Digits)**

YOUR ADDRESS **CITY** **STATE** **ZIP**

☐ Please check this box if this is a change of address.

To ensure you receive notification of claim(s) status, please update your Email address in the Benefits Portal at www.ThePreferredGroup.com .

Unreimbursed Medical Expenses

Receipts must include description of service, date of service, and amount.

	Nature of Service	Date(s)	Amount
1			$
2			$
3			$
4			$
5			$
6			$
7			$
8			$
9			$
10			$
		TOTAL	**$**

Dependent/Child Care Expenses

Submit receipt including date of service, amount, and SS# or Tax ID#
***OR** have provider fill out and sign below*

Name of Day Care Provider	Signature of Provider	SSN / Tax ID

Name of Dependent	Age	Disabled
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

	Description of Service	Date(s)	Amount
1			
2			$
3			$
4			$
		TOTAL	**$**

Premium Expenses

(Privately held insurance policies)

	Type of Insurance	Dates of Coverage	Amount
1			$
2			$
		Total	**$**

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for re-crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

SIGNATURE ***Date***

Send completed vouchers to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(518) 591-4960 (866) 989-8995
Fax: (518) 641-0325
www.ThePreferredGroup.com

Minimum Request:$25.00

++SEE REVERSE FOR DETAILS

* HOW TO COMPLETE YOUR REIMBURSEMENT VOUCHER *

FILLING OUT YOUR REIMBURSEMENT VOUCHER:

- Fill out *your* employer's name, *your* name and *your* address. The address on the voucher is the address to which your check will be sent. Please be sure to update your e-mail and mailing address at our website. Having the most current information will allow us to more rapidly notify you of your claim status, and enable you to receive your reimbursement faster. *If you do not have access to the web, be sure to check the "Change of Address" box on the front of this form.*
- Be sure to fill in the last 4 digits of your Social Security Number and your home and work telephone numbers.
- *Sign* and date your voucher. Your claim cannot be processed without your signature.
- Please provide a specific description of your expenditures under the "description" column.
- Fill out the total amount of your claim in each category: Medical and Dependent Care.

SUBMITTING YOUR CLAIMS FOR REIMBURSEMENT:

- Please be sure that the claims that you are submitting for reimbursement are allowable expenses. There are some specific expenses that are not allowed under various Flex plans. For example, cosmetic procedures, child care while one spouse is at home, and premiums for group-term life insurance are not reimbursable expenses.
- You will need to attach *copies of third-party invoice(s)* to substantiate your claim. These may include receipts, insurance Explanation of Benefits (EOB) or other documentation. *Canceled checks cannot be accepted as proof of a reimbursable expense.* Each invoice must contain the following information:
- *Date of Service.* Reimbursement is made based on date of service, not on date of payment.
- *Nature of Service.* Receipts must specify the nature of service so that we may determine its eligibility under the Flex plan.
- *Individual Receiving Service.* Only plan participants and their dependents may be eligible for Flex benefits.
- *Amount of Service.* Please provide documentation indicating the cost of services for which you are responsible.

++UNREIMBURSED MEDICAL EXPENSES:

- Certain UNREIMBURSED MEDICAL EXPENSES may require a prescription from a licensed physician indicating the medical necessity, and condition, for which the items are required. A new prescription is required for each condition, and for continuing conditions at the beginning of each plan year.
- Certain FDA approved Over-the-Counter drugs and medicines which are used to treat an illness or injury may be reimbursed with a third-party receipt showing the printed date of purchase, description, dollar amount and name of provider.
- Expenses covered by your insurance can only be submitted to PGP *after* they have been submitted to your insurance carrier. When you receive your Explanation of Benefits, submit the *unpaid balance* to PGP. We cannot reimburse you before we know how much of your claim will be covered by your insurance carrier.
- Expenses *not* covered by your insurance should be submitted along with a statement from either you or your insurance carrier indicating that the expenses will not be reimbursed.

DEPENDENT DAY CARE

- For DEPENDENT DAY CARE claims please list your provider's name and either Social Security or Tax ID number.
- If no receipt is provided, please have your daycare provider complete the dependent day care section of this voucher and sign at the signature line.*
- You can submit vouchers at any time, but you will only be reimbursed up to the amount that is in your Dependent Day Care Account at the time your voucher is received. The balance of the claim will be paid automatically as money is deposited in your account.

SUBMITTING YOUR CLAIM ONLINE:

Log In to : www.ThePreferredGroup.com
Click on "View/Create Messages"
Then "Compose New Message"
In the "TO" box select "submit claims" and click on "Insert Checked Contacts"
"Browse" to find your document(s).
"Add" your document(s) including your completed voucher.
Be sure the paperclip appears showing that your documents have been attached BEFORE you hit "Send"
Click on "Send"

If you have any questions regarding your Flex Account, please contact The Preferred Group at (518) 591-4960 or (866) 989-8995 from 8 AM to 5 PM Monday through Friday.

PREFERRED PG GROUP
CUSTOM BENEFITS SOLUTIONS

CLAIM SUBMISSION GUIDELINES

P.O. Box 15136, Albany, NY 12212
www.ThePreferredGroup.com

The federal regulations governing the administration of Flexible Spending Accounts (FSAs) are definitive and specific regarding reimbursements through the FSA.

You will need to attach *copies of third-party invoice(s)* to your completed voucher to substantiate your claim. These may include receipts, insurance Explanation of Benefits (EOB) or other documentation. *Canceled checks cannot be accepted as proof of a reimbursable expense.*

Each invoice must contain the following information:

Date of Service. Reimbursement is made based on date of service, not on date of payment.
Nature of Service. Receipts must specify the nature of service so that we may determine its eligibility under the Flex plan.
Individual Receiving Service. Only plan participants and their dependents may be eligible for Flex benefits.
Amount of Service. Please provide documentation indicating the cost of services for which you are responsible.
Tax ID# required for Dependent Care

Dependent Care Expenses - $5,000 Maximum

An eligible dependent is any dependent who is less than 13 years old and your dependent under federal income tax rules. An eligibile dependent may also include your mentally or physically impaired spouse or a dependent who is incapable of caring for him or herself (for example, an invalid parent). The dependent must spend at least eight hours per day in your home.

Child care services will qualify for reimbursement from the Dependent Care Reimbursement Account if they meet these requirements:

- The child must be under 13 years old and must be your dependent under federal income tax rules.
  Note: if your child turns 13 during the year, you cannot stop your contribution at that time.
- The services may be provided inside or outside your home, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child).
- If the services are provided by a day-care facility that cares for six or more children at the same time, it must be a qualified day-care center.
- The services must be incurred to enable you, or you and your spouse if you are married, to be employed.
- The amount to be reimbursed must not be greater than your income or the combined income of an employee and spouse, whichever is lower.
- Services must be for the physical care of the child, not for education, meals, etc.

Allowable Dependent Care expenses include payments to the following when the expenses enable you to work*:

- Child care centers
- Family day care providers
- Babysitters
- Nursery Schools
- Caregivers for a disabled dependent or spouse who lives with you
- Household services, provided that a portion of these expenses are for a qualifying dependent incurred to ensure the dependent's well-being and maintenance

Dependent Care expenses that are **NOT** eligible:

- Dependent care expenses that are provided to one of your dependents by a family member, unless the family member is age 19 or over by the end of the year and will not be claimed as a dependent.
- Expenses for food and clothing
- Education expenses from kindergarten on
- Health care expenses for your dependents
- Overnight camps

*refer to IRS publication 503 for additional information

Flexible Spending Account Expenses that are Eligible

The following list identifies *some* of the common medical, dental and health related expenses that the IRS* considers to be deductible expenses. These expenses are eligible for reimbursement through your FSA provided that you have not been reimbursed for them through any other benefits plan.

Abortion, legal
Acupuncture
Alcoholism treatment
Ambulance
Artificial limbs and teeth
Birth control pills
Braces
Braille books and magazines (to the extent prices exceed prices for regular books and magazines)
Car (special medical equipment within)
Contact lenses including saline solution and enzyme cleaner (must submit cash register receipt)
Crutches
Dental treatment
Diathermy
Durable Medical Equipment
Electrolysis or hair removal (medically necessary)
Examination, physical
Eye examination
Eyeglasses
Fees for health club (medically necessary)
Fees to doctors, hospitals, etc. for:
- Anesthesiologist
- Chiropractor
- Christian Science practitioners
- Clinic charges
- Dentist
- Dermatologist
- General Practitioner
- Gynecologist
- Internist
- Midwife
- Neurologist
- Obstetrician
- Ophthalmologist
- Optometrist
- Osteopath, licensed
- Podiatrist
- Practical Nurse
- Psychiatrist
- Psychoanalyst (medical care only)
- Psychologist (medical care only)
- Sex therapist (medical care only)
- Surgeon

First Aid Supplies
Guidedog and its upkeep
Hair transplant (medically necessary)
Health spa in home (to extent value of home not increased)
Hearing aids and batteries
Hospital services
HMO (Health Maintenance Organization) co-payments
Insulin
Iron Lung
Laboratory Fees
Lead-based paint removal to prevent lead poisoning
Legal fees to allow treatment for mental illness
Lip-reading lessons
Lodging for medical care
Medical information plan (amounts paid to plan that keeps your medical information)
Mentally retarded, special home
Nurses' expenses and board
Nursing care
Nursing home (if for medical reasons)
Operations and related treatments
Over-The-Counter-Drugs (RX generally needed)
Oxygen equipment
Prescribed drugs and medicine
Radial Keratotomy
Rental of medical equipment
Sanitarium
Smoking cessation programs
Special schooling for physically or mentally handicapped family member
Sterilization
Telephone (for the deaf)
Television equipment which displays the audio part of TV programs for the deaf
Therapy (for medical treatment)
Transplants
Transportation costs to and from doctor, hospital and/or Pharmacy *
Vitamins (that require a prescription for purchase)
Weight loss programs (physician approved)
Wheelchair
Wigs to cover baldness due to medical reasons
X-ray

* refer to IRS publication 502 for additional information
See an A-Z listing on www.ThePreferredGroup.com.

Flexible Spending Account Expenses that are NOT Eligible

Any illegal treatment
Cosmetic services and procedures (unless necessary to restore normal functioning)
Medications specifically used for cosmetic purposes
Cost of remedial reading classes for non-disabled child
Dancing or ballet, even when recommended by doctor
Funeral expenses
Food for weight loss programs
Diaper service
Health and beauty aids
Insurance premiums
Over-The-Counter-Drugs for general well being (including health & beauty aids, vitamins, and nutritional supplements)
Teeth whitening