



BASIC FLEX REIMBURSEMENT FORM

MAIL or FAX claims to BASIC at:
9246 Portage Industrial Drive, Portage, MI 49024
Fax: 269-327-0716 or 800-391-6562
For questions Call: 269-327-1922 or 800-444-1922 x 1

Company Name: _____

Employee Name: (Please print or type): _____

Social Security Number: _____ Phone: _____

My NEW address is: _____

E-MAIL ADDRESS: _____

MEDICAL EXPENSES

Date of Service	Physician or other Provider	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL MEDICAL EXPENSES TO BE REIMBURSED \$ _____

I have HEALTH insurance: Yes No DENTAL insurance: Yes No VISION Insurance: Yes No

DEPENDENT/CHILD CARE EXPENSES

Name of Dependent Care Provider: _____ Provider's Taxpayer ID# _____

Address of Provider: _____

Name of Dependent(s): _____

Services From: _____	To: _____	Amount: \$ _____
From: _____	To: _____	Amount: \$ _____
From: _____	To: _____	Amount: \$ _____

TOTAL DEPENDENT EXPENSES TO BE REIMBURSED \$ _____

*Signature of Care Provider _____ Date: _____

I verify that the above information is true and correct and that the expenses claimed above are eligible expenses under the plan.

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

*****Employee Signature: _____ Date: _____

You must sign this form to be reimbursed.

*If you DO NOT have a receipt your claim will not be reimbursed unless your daycare provider has signed this form.

FOR ADMINISTRATIVE USE ONLY

Reviewed By: _____ Date: _____ Plan Year: _____ Approved: \$ _____ Denied: \$ _____

Reason for Denial: _____ Action: _____

INSTRUCTIONS FOR MEDICAL AND DEPENDENT CARE REIMBURSEMENT ACCOUNTS

- Only employees participating in the plan can submit a reimbursement form.
- Employees may be reimbursed from the plan at any time during the plan year.
- Reimbursements may only be made for eligible expenses incurred during the plan year.
- Complete the information on the reimbursement form for each amount claimed.
- If you receive reimbursement for expenses, you may not claim these expenses for income tax purposes.
- **You must sign the form**, thereby swearing that you have not and will not submit these expenses for reimbursement from another plan.
- Submit your reimbursement form and documentation to BASIC, 9246 Portage Industrial Drive Portage MI 49024, or fax to 269-327-0716 or 800-391-6562 or e-mail basic@basicflex.com.

MEDICAL REIMBURSEMENT ACCOUNT

- Documentation must be invoices or other written statements from the third parties that provided the services.
- **The documentation must show the providers name and address, the dates the services were provided, the amounts charged for the services, and a brief description of the services.**
- **For services that you have insurance coverage, you MUST submit the Explanation of Benefits from your insurance company.**
- Orthodontics cannot be reimbursed for the entire amount. Claims for the initial down payments usually associated with the appliances and monthly payments will be accepted as the charge for the medical service rendered for the month.
- In general, the types of expenses for medical services that can be reimbursed by the Plan are the same types of expenses that the Internal Revenue Service would allow for the health expense deduction under Internal Revenue Code Section 213. Further information can be found by obtaining IRS Publication 502 by calling 1-800-829-3676.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

- You may have your provider sign the claim form in the appropriate place or attach a separate receipt from you provider.
- You must show the name, address, and tax identification number of the provider, the dates the services were provided and the amounts charged for the services.
- If your expenses qualify for reimbursement from the Plan, you will be reimbursed for the total of your expenses, but not more than your account balance in the Plan. Your account balance is the total of the deposits you've made into your Dependent Care Flexible Spending Account minus the reimbursements you've received.
- In general, the types of expenses for dependent care services which can be reimbursed by the Plan are the same type of expenses which the Internal Revenue Service would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Service Code Section 21(b)(2). Further information can be found by obtaining IRS Publication 503 by calling 1-800-829-3676.