

SECTION 125 PLAN



LIMITED PURPOSE HEALTH FSA CLAIM FORM (Limited to Dental, Vision, Preventive and Post-Deductible Expenses)

Employee Name: _____ SSN: (last 4 digits only) _____

Plan Year: _____ through _____

The undersigned participant in the plan requests reimbursement in the amounts shown below: (If additional space is needed, please use an additional form.)

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the provider) showing the nature, date and cost of the service provided. For preventive care and post-deductible expenses, you must submit a copy of the Explanation of Benefits (EOB) form for your claim.

MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount

READ CAREFULLY

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the City of Traverse City Section 125 Plan with respect to such expenses and that such expenses have not been reimbursed and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is 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 the payment of all related taxes including federal, state or City income tax on amounts paid for the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee's signature: _____ Date: _____

Please keep a copy for your records

Qualifying Limited Purpose Health FSA Expenses

- * Dental Expenses - Dental expenses, including orthodontics;
- * Vision Expenses - Vision expenses, including examinations, eyeglasses, contact lenses, laser surgery and seeing-eye dogs;
- * Preventive Care Expenses - Preventive care expenses, including periodic health evaluations, tests and diagnostic procedures ordered in connection with routine exams such as annual physicals, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs and selected screening services. Preventive care does not include any prescription or over-the-counter medications or any service or benefit intended to treat an existing illness, injury or condition;
- * Post Deductible Expenses - Medical expenses that are incurred after the annual deductible under your HDHP has been satisfied.

These expenses are reimbursable only if they are not paid under any other insurance policy or health care plan.