



Flex & Child Care Reimbursement Form

This and other important forms are available at:
www.jemtpa.com

Complete, Sign and Send form, receipts and EOBs to:

JEM Resource Partners Fax: 888-989-9247
 4201 Bee Caves Rd. Suite C-101
 Austin, TX 78746

Participant Name: _____ Employer Name: _____

Social Security #: _____ Work Phone #: _____ Home Phone #: _____

Home Address: _____

Out of Pocket Medical or Dental Expenses (Not covered by a Group Medical or Dental Plan):

Please attach copies of paid receipts that show the type of medical or dental expenses; for expenses covered by a Group Medical Plan, attach an Explanation of Benefits (EOB) and paid receipts.

Expenses for:	Date of Birth	Relationship to Participant	Services Provided by	Date of Services	Total Expense	Payment by Insurance	Out of Pocket Expense

Are any of these expenses covered by Medicare or another Group Medical or Dental Plan (this does not include your Employer's Group Plan)? No

Yes - Name of Group Medical/Dental Plan Company _____

Name of Insured under the Plan listed above _____

Dependent Care Reimbursement (Please attach receipts from Provider)

Expenses Incurred for (Dependent's Name)	Date of Birth	Relationship to Participant	Services Provided by	Date Service Began	Date Service Ended	Out of Pocket Expense

Provider Name: _____ Federal ID or SS#: _____ Phone: _____

Provider Name: _____ Federal ID or SS#: _____ Phone: _____

I certify that the expenses listed above have been incurred by me during this Plan Year and qualify for reimbursement under this Plan. (see page 2 or your Employer's 125 Plan booklet for a description of eligible expenses). I also understand these expenses no longer qualify as tax deductions or credits. The paid bills, receipts or other proof of these expenses are attached. I hereby authorize any physician, hospital, or other organization or person having any records, data, or information concerning health history or other insurance for my minor dependents, or me, to furnish such records, data, or information as may be requested by my Employer and/or JEM Resource Partners, Inc.

Signature

Date

**DESCRIPTION OF ELIGIBLE EXPENSES
UNDER YOUR 125 CAFETERIA PLAN FLEXIBLE SPENDING ACCOUNTS**

Health Care Expenses:

Health care expenses are expenses incurred for you, your spouse, or your dependents, which have not been and will not be reimbursed by any medical or dental insurance. Health care includes the prevention, diagnosis, treatment and care of a physical or mental defect, illness, injury or disease. Examples of covered expenses are listed below.

- a) Amounts that are not paid by the medical or dental plan, such as deductibles, coinsurance and amounts in excess of plan limits.
- b) The cost of eye examinations, frames, lenses, contact lenses, hearing examination, and hearing aids that were ineligible under
- c) your group carrier, if any.
- d) The cost of prescription drugs that were ineligible under your group carrier, if any.

Examples of expenses that are not covered are listed below.

- a) Expenditures that are merely beneficial to the general health of the person, such as exercise, fitness, nutrition, recreation
- b) Vacation or membership in a spa or health club
- c) Amounts paid for meals while receiving medical care away from home
- d) Costs of toiletries or cosmetics
- e) Amounts compensated for by insurance

- f) Expenses incurred by a terminated employee after his/her termination date

Dependent Care Expenses:

Dependent care expenses are expenses incurred to enable you to work. If you are married, and your spouse is not a full-time student or is not incapable of self-care, the expenses must be to enable you and your spouse to work. The expenses must be for the care of your dependent who is under age 13 and for whom a personal exemption deduction is allowed for federal income tax purposes, the care of your dependent or spouse who is physically or mentally incapable of self-care, or household services in connection with the care of such a person. Examples of covered dependent care expenses are listed below.

- a) Amounts paid to a childcare center, babysitter, or nurse.
- b) Amounts paid for services performed outside your home for the care of your dependent or spouse. If the care is for a dependent who is age 13 or over or for your spouse and the dependent or spouse is incapable of self-care, the dependent or spouse must spend at least 8 hours a day in your home to qualify for dependent care reimbursements.
- a) The full amount paid to a nursery school, even though the school provides lunch and educational services. No amount of educational services are eligible in the first grade or higher.
- b) Amounts paid to a maid or cook, if services are in conjunction with dependent care service provided to a person who qualifies for dependent care.
- c) Amounts paid to a relative who provides dependent care services, if the relative is not your dependent or your spouse's dependent for whom a personal exemption deduction is allowed for federal income tax purposes, and is not your child or stepchild who is under age 19 at the end of the year.

Examples of expenses that are not covered are listed below.

- a) The cost of food, clothing and education.
- b) The cost of transportation between your house and the place where dependent care services are provided.
- c) The cost of a childcare center that provides care for more than six nonresidents, but which does not comply with all applicable laws.
- d) Expenses for which a dependent care tax credit is taken.