

College of Coastal Georgia
Health Care Flexible Spending Account
Request for Reimbursement

Claims for reimbursement must be submitted to the CCG Human Resources Office. Supporting documentation **must** be attached to the claim. The supporting documentation required is as follows:

If the expense is a covered benefit under a dental or health insurance plan: If the expense is covered by insurance, it must be filed with your insurance plan(s) first. After the expense is filed with insurance, you should receive an Explanation of Benefits (EOB) from your insurance plan(s). You may request reimbursement from your spending account by completing this "Request for Reimbursement" and attaching a copy of the EOB you received from the insurance plan(s). If the expense is for a prescription drug, you will attach a copy of the itemized receipt you receive from the pharmacy. Claims will not be accepted without proof of what your insurance plan(s) did or did not pay.

If the expense is not a covered benefit under a dental or health plan, or if you have NO insurance: Attach an itemized receipt or invoice to this "Request for Reimbursement". The receipt or invoice must state the name and address of the service provider, the date and cost of the service, and what service was performed or provided.

Employee's Name (Please Print)

Division or Department

Does this reimbursement request include expenses for one or more dependents? Yes No
 If yes, complete the following information on the dependent(s) who incurred the expenses.

| Dependent's Name | Date of Birth | Age | Relationship to Employee | Full-time Student? |
|------------------|---------------|-----|--------------------------|--------------------|
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Amount of Reimbursement Request: \$ _____

Calendar Year In Which Service(s) Occurred: _____

EMPLOYEE'S CERTIFICATION

I hereby certify by my signature below that: (1) The expenses were incurred by me or by my eligible dependents during a period in which I was a participant in the CCG Health Care FSA Plan; (2) These dental or health care expenses were not paid by the dental or health care coverage provided through my employer or by any other plans or policies, such as coverage provided by my spouse's employer; (3) The expenses I am claiming will not be reimbursed to me from any other source as they are either (a) not covered by my dental plan, health plan, or any other policies or (b) represent amounts not paid by such plans or policies, such as deductibles, co-payments, etc.; (4) The expenses for which I am requesting reimbursement have been, or will be, paid to the dental or health care provider who rendered the service; (5) I understand the expenses must meet the criteria of an "eligible expense" in accordance with the CCG Health Care FSA Plan and in accordance with Section 213 of the Internal Revenue Code; (6) I assume responsibility for any tax reporting or other legal requirements regarding the reimbursed expenses; (7) I understand that the expenses for which I am requesting reimbursement may not be claimed as an itemized deduction on my income tax return; (8) I understand the Plan Administrator may suspend or deny reimbursement for any expense which does not appear to be eligible for reimbursement under the College's Health Care FSA Plan and/or which does not appear to be in accordance with the respective IRS rules and regulations; and (9) If necessary, I authorize the release of any medical information required to process this claim.

Employee's Signature

Date

Copy Distribution – Send original to Human Resources after making copy for your records