



Flexible Spending Plan CLAIM FOR REIMBURSEMENT

Name: _____ School District: _____

Address _____ E-Mail Address _____

City _____ State _____ ZIP _____ SS# _____

Unreimbursed Medical Expense Claims (including mileage reimbursement – see sample below)

Date Incurred	Name of Service Provider	Expense Description	Expense Incurred For	Net Amount

Attach appropriate receipts

Total Medical Expense Claims

SAMPLE MILEAGE REIMBURSEMENT (Mileage for trips for medical, dental and vision expenses.)

Date Incurred	Name of Service Provider	Expense Description	Expense Incurred For	Net Amount
2/1/2007	Dr. Jones / 200 Miles @ \$.20 per mile	Mileage	Jane Doe	\$40.00

Dependent Care Expense Claims (For Child Care, Day Care or Babysitting expenses ONLY)

Name of Dependent(s)	Period Covered		Name, Address & Taxpayer I.D # of Provider of Service	Amount Incurred
	From	To		

Attach appropriate receipts

Total Dependent Care Expense Claims

READ CAREFULLY: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submissions of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed under any other health coverage. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless expenses for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

Signature _____

Date _____

3 Ways to File a Claim

1. Fax to: **816-968-0557** Attention: Section 125
2. E-mail: Scan your claims and email to: tcox@ftj.com
3. Mail to: Group Insurance Administrative Office
Attn: Section 125 Dept 3130 Broadway
PO Box 418131 Kansas City, MO 64141-9131

Questions?

Call Tim Cox
800-821-7303 ext 1158
or e-mail: tcox@ftj.com

CLAIM FILING INSTRUCTIONS

Who Can File a Claim Form

- Active employees participating in the Cafeteria Plan can file a claim during the plan year and for a certain period after the plan year as described in the Summary Plan Description.
- Terminated employees can file a claim for a certain period after the date of termination if allowed by the Plan. Please see your Summary Plan Description.

What Expenses Can Be Claimed

- Only expenses incurred during the plan year can be claimed for reimbursement. Each year is treated separately and the year of claim is the year the expense was actually incurred by the participant
- Allowable expenses are the same as those allowed for tax purposes.

Qualifying Dependent Care Expenses

- Expenses paid to a dependent care center or care provider
- Expenses paid for the care of a dependent under age 13
- Expenses paid for care of other dependents who are physically or mentally incapable of caring for themselves.
- Expenses paid for tuition for preschool up to Kindergarten.

Qualifying Unreimbursed Medical Expenses -

Acupuncture (excluding remedies and treatments prescribed by acupuncturist)	Fees: Acupuncture Anesthetist Blood Donor Diagnosis Diathermy Examination, physical Eye examinations Gynecologist Hearing Services Hospital Laboratory Laetrile, where prescribed by doctor Lip reading lessons for the deaf	Medical information plan Midwife Nurse Obstetrician Oculist Ophthalmologist Optician Optometrist Oral Surgery Osteopath Pediatrician Physician Psychotherapist Podiatrist Psychoanalysis Psychologist	Psychotherapist Sex Therapist Specialist Surgeon Therapy Halfway house residency Hearing Devices Hospital Bills Iron Lung Laser Eye Surgery Mileage (Medical, Dental, Vision) Nursing Care Obstetrical Expense Operations & related treatment	Rental of medical or hearing equipment Retirement home less portion allocable to medical care Seeing eye dog Special education Support or corrective device (including special mattress and board for arthritis Telephone for deaf Television set modification for closed captions Therapy treatment Transportation expenses relating to illness Wheelchairs X-Rays
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Examples of Over the Counter Medicines Covered:

Acne medications	Bee sting kits	Cough drops, lozenges	Incontinence supplies	Pain reliever
Allergy medicines	BenGay	Crutches	Laxatives	Pedialyte for dehydration
Antacids	Bug bite ointments	Denture adhesives	Menstrual pain products	Pregnancy tests
Antidiarrhea medicine	Calamine lotion	Diabetic supplies	Motion sickness pills	Rubbing alcohol
Anti-itch medicines	Cold Medicine	Diaper rash ointments	Muscle pain creams	Sinus sprays
Aspirin	Cold packs	First aid kits/creams	Nasal strips	Sleeping aids
Bactine	Condoms	Gauze pads	Nicotine gum & patches	Sunburn ointment
Band-Aids, bandages	Contact lens solution	Hot pak	Ovulation tests	Suppositories

Examples of expenses that DO NOT qualify: Cosmetic surgery and procedures, Dental bleaching, Marriage and family counseling.

How to file the Claim Form

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year.
- Attach a copy of a bill, invoice, or other written statement from a third party which supports each reimbursement request.
- **Mail to:** Group Insurance Administrative Office
Attn: Section 125 Dept.
3130 Broadway PO Box 418131
Kansas City, MO 64141-9131

Changes in Plan Participation during the year

You can change your participation during the plan year only if you have a change in family status. "Change of family status" includes birth, death, marriage, divorce, change of employment by the spouse, or certain other situations as determined by the Plan Administrator