bac

CLAIM FORM – FOR FSA AND DCAP

ANSWER ALL QUESTIONS FULLY, ATTACH BILLING/RECEIPT/EXPLANATION OF BENEFITS (EOB), AND FAX TO BAC AT **(614) 863-0184**, OR MAIL TO **PO BOX 107, REYNOLDSBURG, OH 43068-0107**

A. STATEMENT OF PARTICIPANT: PLEASE ANSWER ALL QUESTIONS FULLY

EMPLOYERS NAME:

EMPOLYEE NAME (LAST, FIRST, M.):

SOCIAL SECURITY NUMBER:

HOME ADDRESS: CITY: STATE: ZIP CODE:

PHONE NUMBER:

DATE OF BIRTH (MM/DD/YYYY):

EMAIL ADDRESS:

IS THIS A NEW ADDRESS?:

B. QUALIFIED TAX-FREE REIMBURSEMENT (SEE REVERSE): ATTACH DETAILED BILLING/RECEIPT AND/OR AN EOB

1. CLAIMANT: DATE: AMOUNT:

PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):

EXPENSE TYPE: ◯ **FSA** ◯ **DCAP**

2. CLAIMANT: DATE: AMOUNT:

PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):

EXPENSE TYPE: ◯ **FSA** ◯ **DCAP**

3. CLAIMANT: DATE: AMOUNT:

PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):

EXPENSE TYPE: ◯ **FSA** ◯ **DCAP**

! TO BE ELIGIBLE FOR REIMBURSEMENT YOU MUST: INCUR THE EXPENSE AS AN ACTIVE PARTICIPANT DURING THE CURRENT PLAN YEAR, AND SUBMIT THE PROVIDER BILL TO BAC WITH CLAIM FORM ATTACHED. FOR FLEXIBLE SPENDING ACCOUNT EXPENSES, PLEASE MAKE SURE YOUR PROVIDER BILL IDENTIFIES THE PATIENT, THE PROVIDER AND THE DATE OF SERVICE.

FOR DEPENDENT CARE PLEASE ATTACH YOUR PAID RECEIPT AND LIST THE PROVIDER'S NAME, ADDRESS AND SOCIAL SECURITY OR FEDERAL TAX I.D. NUMBER (THIS INFORMATION IS REQUIRED IN ORDER THAT YOU MAY BE ABLE TO DEDUCT THESE ITEMS ON YOUR INCOME TAX RETURN).

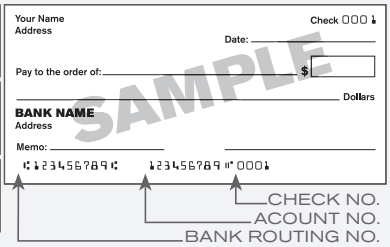
C. ACCOUNT INFO: COMPLETE THIS SECTION IF THIS IS YOUR FIRST CLAIM OR YOUR BANK ACCOUNT HAS CHANGED

PAYMENT METHOD:

PLEASE: ◯ **MAIL ME A CHECK** ◯ **ELECTRONICALLY TRANSFER FUNDS INTO MY BANK ACCOUNT**

BANK ROUTING NUMBER (SEE ILLUSTRATION AT RIGHT):

YOUR ACCOUNT NUMBER (SEE ILLUSTRATION AT RIGHT):



D. AUTHORIZATION:

THE EXPENSES SUBMITTED FOR PAYMENT HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE OR BY ANY OTHER FORM OF REIMBURSEMENT

X _____ _____

EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

E. INSTRUCTIONS:

ELIGIBLE HEALTH CARE EXPENSES:

In general, an employee may be reimbursed for a health care expense which qualifies as a deduction on the Federal Income Tax return, (Section 213 Expenses) but which has not or will not be reimbursed by any other source and has not been or will not be deducted on the employee's income tax return. (See examples below)

SUPPORTING DOCUMENTATION (For Eligible Health Care Expenses)

The following supporting documentation must be attached to your claim form:

1. **MEDICAL EXPENSES COVERED UNDER ANY HEALTH BENEFIT PLAN MUST FIRST BE SUBMITTED TO THAT PLAN FOR PAYMENT,** before you may apply for reimbursement through your Flexible Spending Account. After you have filed with the other plan, attach a copy of their Explanation of Benefits statement (EOB) so that you may be reimbursed for the out-of-pocket expenses not paid by the other health benefit plan.
2. **IF YOUR HEALTH BENEFIT PLAN OR YOUR SPOUSE'S HEALTH BENEFIT PLAN IS ADMINISTERED BY BAC,** please submit a completed Flex Claim Form along with your regular claim submission. This will enable BAC to reimburse you you through your Flexible Spending Account, for out-of-pocket expenses not paid by the Health Benefit Plan.
3. **OVER-THE-COUNTER EXPENSES,** attach original cash register receipt that clearly states name of drug, date of purchase, and name of pharmacy where purchased.
4. **FOR ALL OTHER EXPENSES,** attach bills that clearly state:
   - **a.** name of person receiving service
   - **b.** nature of service or supplies
   - **c.** name and address of provider of service
   - **d.** amount charged
   - **e.** date of service

ELIGIBLE DEPENDENT CARE EXPENSES:

In general, the following rules apply to Dependent Care Expenses:

The expenses must be employment-related expenses for the care of a dependent who is:

1. under age 13, or
2. a dependent who is physically or mentally incapable of caring for himself or herself.

The services cannot be provided by a person who is a claimed as a dependent of the employee.

If the services are provided by a dependent care center which provides care for more than six individuals, the center must comply with all state and local laws.

SUPPORTING DOCUMENTATION
(For Eligible Dependent Care Expenses)

Complete the information on the front of this claim form and send a copy of the billing from the Dependent Care Provider.

If your Dependent Care Provider is not a formal business that uses a standard billing form, then you should provide the name, address, and Social Security number of the individual provider.

*** This is only a summary in outline form of the benefits and rules of the Plan. Eligible persons who choose to participate should review the PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION (Benefit Booklet) for information about; participation, benefits, year end timely filing limitations and other limitations and exclusions. This is not a contract, policy or guarantee of coverage. ***

A QUALIFIED MEDICAL EXPENSE AS DESCRIBED IN SECTION 213 OF THE INTERNAL REVENUE CODE IS BROADER THAN WHAT IS COVERED UNDER A TYPICAL MEDICAL, DENTAL, OR VISION PLAN.

EXAMPLES INCLUDE:

- Medical, dental, and vision expenses not covered by insurance or other plans
- Alcoholism and drug addiction treatment
- Fertility and sterilization treatments
- Nursing home and certain long-term care services
- Travel expenses (mileage, parking, lodging, etc.) necessary to receive medical care
- Special controls, equipment, or improvements to accommodate a disabled family member
- Laser eye surgery, contact lenses, and cleaning solutions
- Dentures, orthodontics, including braces
- Hearing tests, hearing aids, and batteries
- Bandages, canes, crutches, and wheelchairs
- Over-the-counter drugs (non-prescription) **Includes:** headache and cold medicines, antacids, topical pain remedies, cough drops, etc.

NOT COVERED ARE NON-QUALIFIED MEDICAL EXPENSES.

EXAMPLES INCLUDE:

- Cosmetic surgery and procedures unless needed to correct deformity due to an accident, illness, or birth defect
- Health club membership
- Weight loss unless prescribed by a physician and related to a specific diagnosis
- Vitamins and nutritional supplements
- Bottled water and hygiene products
- Hair transplants and hair removal
- Domestic help or diaper services

MAIL COMPLETED FORM TO BAC AT:
PO BOX 107
REYNOLDSBURG, OH 43068

OR FAX COMPLETED FORM TO BAC AT:
(614) 863-0184