IPG FLEX PLAN
REIMBURSEMENT CLAIM VOUCHER

EMPLOYEE NAME: ________________________________ **SOCIAL SECURITY #:**_____________

MAILING ADDRESS: ________________________ **CITY:** _____________ **STATE:** _____ **ZIP CODE:** __________

EMPLOYER: ______________________________ **PLAN YEAR:** _______

Please read the Instructions on the back of this form and the FSA Rules in your SPD before completing this voucher.

MEDICAL REIMBURSEMENT ACCOUNT CLAIMS

Name of Person Service Covers	Date Service Performed	Description of Service including Name of Service Provider	Net Claim Amount
______________	_________	____	$_________
		____	
______________	_________	____	$_________
		____	
______________	_________	____	$_________
		____	
______________	_________	____	$_________
		____	
______________	_________	____	$_________
		____	

TOTAL MEDICAL REIMBURSEMENT CLAIM $_________

DEPENDENT CARE ACCOUNT CLAIMS:

Name of Dependent(s)	Dates of Service	Service Provider Name and Address with Taxpayer ID Number	Claim Amount
______________	_________	____	$_________
		____	
		____	
______________	_________	____	$_________
		____	
		____	
______________	_________	____	$_________
		____	
		____	

TOTAL DEPENDENT CARE CLAIM $_________

Please Read Carefully

I request payment for these expenses from my flexible spending account(s). I certify that the above information is a true and accurate statement of unreimbursed expenses incurred by **me or my eligible dependents** on the date(s) indicated, and were incurred while I was covered under my employerøs Plan. These expenses have not been nor will ever be reimbursed by another source or claimed on my personal income tax return. I understand that I may be liable for payment of all related taxes including Federal, State and/or City income tax on the amounts paid for any expense improperly claimed under the Plan.

Signature: ________________________________ **Date:** ___________________ **Email:**_________________________

INSTRUCTIONS

ACCOUNT RULES AND CLAIM FILINGS:

ÉOnly employees participating in the Plan may submit a claim voucher.
ÉEmployees can submit a voucher at any time during the plan year and for a specified grace period after the plan year as described in their Planøs Summary Plan Description.
ÉTerminated employees can submit a voucher for a specified grace period after the date of termination as stated in their Planøs Summary Plan Description.
ÉReimbursements can only be made for eligible expenses incurred during the coverage period in which your contributions were made.

ÉIRS rules stipulate that any money left over in your account(s) after all reimbursements for the plan year have been processed cannot be carried forward or returned.
ÉMoney in one account cannot be used to cover expenses incurred in another account. For instance, any unused amounts left in the medical reimbursement account cannot be used to reimburse dependent care expenses.
ÉYou cannot claim for a service period that begins in one plan year and ends in the next plan year. Two separate claim vouchers will need to be submitted; one for each plan year covering the period of service during that plan year.
ÉThe maximum amount available to you in a Dependent Care FSA at any time is only the amount currently in the account.
ÉDocumentation supplied for processing will not be returned. Use photocopies when possible.
• **Claims cannot be processed unless ALL of the information on the voucher is completed.**
ÉCopies of receipts from service providers and/or the Explanation of Benefits Form from Insurance Carriers may each qualify as substantiation.

• **SIGN AND DATE THE VOUCHER.**
ÉSubstantiation must include an independent third-party statement containing all information on the Claim Voucher.
ÉCanceled checks **alone** are not sufficient to document medical reimbursement claims.
• **Claim eligibility is considered based on the *dates of service* not *dates of payment*.**
ÉHandwritten receipts for dependent care are acceptable as documentation.
ÉPayments will only be made directly to you.
• **MAIL OR FAX COMPLETED FORM TO:**

Employee Benefits Specialists

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Fax (603) 358-6882 ˝ Website: www.ipgbenefits.com ˝ Email: info@ipgbenefits.com