

REQUEST FOR REIMBURSEMENT FORM – FLEXIBLE SPENDING ACCOUNT PLAN

EMPLOYER NAME:	<input type="checkbox"/> CALVIN COLLEGE	<input type="checkbox"/> CALVIN THEOLOGICAL SEMINARY	<input type="checkbox"/> < - Please check this box if your address has changed
Employee Name:			Home Address:
Last 4 Digits SS#:			
Email Address:			Phone Number:

INSTRUCTIONS: If this form is incomplete (including NOT SIGNED), it will be returned to you.

Complete the information below for health and/or dependent care expenses incurred by you, your spouse or other eligible dependents for whom you are requesting reimbursement. **You must provide an itemized bill from the provider, insurance Explanation of Benefits (EOB) or other third-party documentation that the expenses were incurred (canceled checks are NOT acceptable).** Print or type the information requested, sign and date the form. Send this completed form along with third-party documentation to Corporate Benefit Strategies, Inc. **See the reverse side of this form regarding CLAIM SUBMISSION DEADLINES.**

HEALTH CARE SPENDING ACCOUNT EXPENSES - (out-of-pocket medical, dental, vision, Rx expenses, etc.)

DATE OF SERVICE <i>(Date services were incurred)</i>	DESCRIPTION OF EXPENSE <i>(Prescription, Office Visit, Dental)</i>	NAME & RELATIONSHIP OF PERSON WHO INCURRED EXPENSE <i>(Example: Bob Jones – Spouse)</i>	PROVIDER OF SERVICE <i>(Pharmacy, Dr. Smith, etc.)</i>	IS EXPENSE COVERED BY ANY OTHER PLAN?*	AMOUNT OF EXPENSE REQUESTED
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
TOTAL EXPENSES					\$

**If the expense is covered by an insurance plan, please submit the insurance EOB with this form.*

If you are submitting a claim for expenses incurred by a dependent and we need further information in order to process the claim, your dependent is deemed to authorize you to respond to our request. To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I certify that my dependent or I have received the services described above on the dates indicated and that the expenses qualify as valid expenses under the Plan. If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent in the plan. I certify that I have not been reimbursed previously for these expenses under the Health Care Spending Account Plan. I certify that these expenses have not been reimbursed, and are not reimbursable under a medical plan, insurance plan, or any other health care FSA plan. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes (hair growth, weight loss, etc.). If the reimbursement requested is for a non-prescription drug, I certify that the drug was purchased for use by me or my spouse or dependent to alleviate or treat an illness or injury and was not purchased for the purpose of promoting overall good health. I understand that these expenses may not be used to claim any federal income tax deduction or credit. I authorize a deduction in my Health Care Spending Account in the amount of the reimbursement.

DEPENDENT CARE SPENDING ACCOUNT EXPENSES - (child/dependent care expenses) FORM MUST INCLUDE PROVIDER'S SIGNATURE IF NO RECEIPT

DATES OF SERVICE <i>(From – Through Dates the Care was Provided)</i>	DEPENDENT'S NAME & RELATIONSHIP	DEPENDENT CARE PROVIDER'S SIGNATURE <i>(Only if no receipt from the provider is attached)</i>	AMOUNT OF EXPENSE REQUESTED
TOTAL EXPENSES			\$

For information as to what dependent care expenses can be reimbursed, see the summary plan description and IRS Publication 503.

Note: To be reimbursed, you must provide the dependent care provider's SIGNATURE (OR a receipt from the provider). You must also provide this information to the IRS on your Federal income tax return (Form 2441). To the best of my knowledge and belief, my statements in this reimbursement Request Form are complete and true. I have read, understand and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Request for Reimbursement form. I understand that these dependent care expenses may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. I authorize a reduction in my Dependent Care Spending Account Plan in the amount of the reimbursement.

EMPLOYEE SIGNATURE	DATE
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IMPORTANT INFORMATION ABOUT YOUR HCFA AND DCFA

The fact that complete and proper claims for benefits made by individuals covered by the Program will be promptly processed, but that in the event there are delays in processing claims, the individuals covered by the Program shall have no greater rights to interest or other remedies against TPA than as otherwise afforded them by law.

1. If your participation in the plan **TERMINATES** (*voluntary or involuntary*), claims may be submitted to CBS after your termination date in the plan for a specific time frame established by your employer – but only for eligible expenses **incurred PRIOR TO your termination in the plan**. Please refer to your specific plan guidelines to determine the claim submission period for terminated participants.
2. IRS rules stipulate that any money left in your account(s) after all reimbursements for the Plan Year have been processed may NOT be carried forward or returned to you. Money left in the HCFA may NOT be used to reimburse dependent care expenses, and vice versa.
3. **ACTIVE participants** (*not terminated*) may submit claims for eligible expenses **incurred during the plan year established by your employer**. A claim submission run-out period is offered after the end of the plan year for you to submit claims against the prior year's balance. **Please refer to your specific plan guidelines to determine the length of time of your claim submission run-out period.**
4. Only employees participating in the plan can submit a reimbursement form.
5. If you receive reimbursement for expenses from your HCFA and/or DCFA, you may NOT claim these expenses for income tax purposes.
6. Additional Request for Reimbursement Forms are available from your Employer's Human Resources Department or CBS' Internet site www.hrbenefitsdirect.com/cbs.

QUALIFYING HEALTH CARE EXPENSES

The Section 125 Plan document contains the rules governing what expenses are and are not reimbursable. Below are some examples to give you a general idea of what items are and are not reimbursable. A detailed Health Care Expense Table is available on CBS' website as well.

Examples of expenses for which you may be able to receive reimbursement include:

- Out-of-pocket medical and dental expenses incurred during the plan year and as defined in Code § 213(d), unless excluded below.
- Deductibles and co-payments that you are responsible for under your primary medical plan, or under any other medical or dental plan, unless excluded below.
- Prescription and over-the-counter drugs to treat a medical condition.
- Eye exams, eyeglasses, contact lenses & other vision expenses.
- Orthodontic and dental expenses (unless cosmetic dental expenses).
- Hearing exams, hearing aids, and other hearing expenses.
- Massage therapy (if prescribed by a physician to treat a specific medical injury or trauma).
- Physical therapy.
- Chiropractor fees.
- Acupuncture.
- Smoking cessation programs.
- Weight-loss programs and/or drugs prescribed to induce weight loss (if prescribed by a physician to treat an existing disease – not to improve general health or for preventive reasons).

EXCLUSIONS - HEALTH CARE SPENDING ACCOUNT

Examples of expenses that are NOT reimbursable:

- Warranties and service agreements (*e.g. eyeglass warranty*) and clip-on sunglasses.
- Health insurance premiums that you or your spouse pay for coverage under another health plan.
- Long-term care services, insurance premiums, and automobile insurance premiums.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a

personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

- Funeral and burial expenses.
- Custodial care.
- Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods.
- Bottled water.
- Maternity clothes, diaper service or diapers, cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements (some may be eligible if prescribed by a physician to treat a specific medical condition).
- Uniforms or special clothing, such as maternity clothing.
- Marijuana and other controlled substances, even if prescribed.

QUALIFYING DEPENDENT CARE EXPENSES

By signing and submitting the Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet *all* of the following conditions:

1. The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year to which the election applies.
2. The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of self-care.
3. The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of (A) your earned income; or (B) if you are married, your spouse's actual or deemed earned income.
Your spouse is deemed to have monthly-earned income of \$300 (\$600 if you are incurring dependent care expenses for more than one dependent), if your spouse either is a full-time student or is physically or mentally incapable of self-care.
4. Each dependent for whom you incur the expenses is (A) a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return, or (B) your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
5. You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(A) or 4(B) above.
6. The expenses are incurred for the care of a dependent, or for related incidental household services.
7. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(A) above (or who is described in 4(B) above and regularly spends at least eight hours per day in your household).
8. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
9. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
10. The expenses are not paid for services outside your household at a camp where the dependent stays overnight.