Flexible Spending Account
Unreimbursed Medical Expenses/ Dependent Care
Request for Reimbursement Form

Employee Information *(Please Print)*

Worksite Employer___________________________

Last Name	First Name	M.I.	Soc. Sec. No. **(Must be provided)**
Street Address	City	State	Zip Code
Home Phone Number ( ) -	Contact Phone ( ) -	Email Address (for confirmation)	

Complete the information below for expenses incurred by you, or your dependents, for which you are requesting reimbursement. If this form is not filled out completely, or is illegible, reimbursement may be delayed or denied, in which case, the claim which will be mailed back to the employee with a letter of explanation. You may use as many forms as necessary so all items and services can be listed, writing "See Attached", will not be accepted.

****PLEASE SEE REVERSE SIDE FOR FURTHER INFORMATION AND INSTRUCTIONS****
Reimbursements will be processed on a *semi-monthly* basis only.

Medical Expenses *(Attach Supporting Documentation)*

Date of Service	Patient/Dependent Name	Description of Service	Name of Provider	Expense Amount
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
			Total Expense $	

Dependent Care Expenses *(Attach Supporting Documentation)*

Date of Service	Dependent Name	Name of Provider	SSN/Federal ID # of Provider	Expense Amount
/ /				
			Total Expense $	

Employee's Certification for Reimbursement

I certify that the statement and information on this reimbursement request form are accurate and true, to the best of my knowledge. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and for expenses incurred by my IRS dependents and me. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and I am not eligible to receive additional insurance benefits or reimbursement from any other source for such expenses. I understand that if I receive reimbursement by another benefit plan that amount of my reimbursement will become taxable and I will notify my employer immediately. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

EMPLOYEE'S SIGNATURE ________________________________ **DATE** ____________

Claims may be submitted by mail:

Staff Leasing Inc, Attn: Flex Department, 149 Northern Concourse North Syracuse, NY 13212

Or via email: flex@staffleasing-peo.com
(We no longer accept faxed claim requests due to illegible or incomplete documents.)

You will be notified via email when your claim is received.

Follow these helpful tips for completing your Staff Leasing Request for Medical Reimbursement:

Please submit all Medical expenses incurred in 2008 no later than March 31, 2009

Please be sure to complete all required sections to ensure quick processing of your request. All fields must be filled in completely; **do not include "See Attached"** in any field.

Do not submit Unreimbursed Medical (URM) claims until after services are rendered.

Attach a legible receipt (or receipts) from the service provider showing:

- A description of the service, or list of supplies furnished.
- The charge(s) for each service.
- The date(s) of each service, **NOT** the date of payment, for services rendered in the plan year, no future dates will be accepted
- The name of person(s) receiving service

Note: Drug receipts must show the drug name. All receipts should be accompanied by a Request for Reimbursement form.

If you carry group insurance, submit expenses to the insurance carrier FIRST. Attach the Explanation of Benefits (EOB) to document reimbursement or to credit your deductible and coinsurance amounts. *An EOB is the statement from your insurance company showing what they have paid, and the patient responsibility balance owed.* Note that reimbursements will not be issued for less than $15. Requests for less than $15 will be applied to future requests.

For Dependent Care Expenses:

Please submit all Dependent expenses incurred in 2008 no later than March 31, 2009. Expenses must include:

- Name and address of person providing care
- The date(s) of each service, **NOT** the date of payment, for services rendered in the plan year, no future dates will be accepted
- Name of dependent receiving care
- Amount charged
- Tax identification or Social Security number
- Receipt must be on provider letterhead or include provider signature

Not Acceptable Forms Of Expenses:

- Billing statements
- Balance forwarded bills
- Previous balance bills
- Cancelled checks
- Credit card statements

All requests for reimbursement must be made via mail or email only. We will no longer accept faxed claim requests due to illegible or incomplete documents. Please mail to Staff Leasing at the address below or email a scanned copy of your documents and receipts to flex@staffleasing-peo.com.

For further questions please contact our Staff Leasing Flex Department directly at 315-641-3600, ext. 152.