



Health Care Spending Account Reimbursement Form

Disbursements will be made on alternating Wednesdays. This form must be completely filled out and received by Zenith Administrators no later than the Friday prior to the disbursement in order to be included.

SECTION ONE: PARTICIPANT INFORMATION

Last Name:	First Name:	M.I.	Home Phone Number:
Mailing Address:			Work Phone Number:
City:	State:	Zip Code:	Participant's Social Security Number: ____-____-____
Is this a new address for you? <input type="checkbox"/> YES <input type="checkbox"/> NO			

SECTION TWO: HEALTH CARE SPENDING ACCOUNT REIMBURSEMENT INFORMATION

In order to receive reimbursement, please complete the following in full, and attach a copy of the Explanation of Benefits (EOB) issued by your insurance company or claim administrator. The EOB shows the uncovered health care expenses and the reason why the claim was not paid or not paid in full. You must provide an EOB for all medical and dental expenses. For vision claims, provide a copy of your provider's invoice showing the patient's name, date of service, type of service, and the amount paid by insurance. For prescription drug claims, you must provide a copy of the prescription receipt showing the patient's name, date of service, type of prescription, and co-payment amount. For over-the-counter drug claims you must provide proof of purchase including name of the medication, the price and the date of purchase and a doctor's prescription if after January 1st 2011.

Patient's Name	Age	Relationship to Participant	Dates of Service	Type of Service (Med/Den/Vis/Rx)	Amount of Requested Reimbursement*

*You must calculate the amount you wish to claim from your health care spending account. We cannot process your reimbursement request without this information. Total: _____

SECTION THREE: PARTICIPANT CERTIFICATION AND SIGNATURE

I request reimbursement for the eligible expenses listed above. I certify that the above information is correct and that I have not received reimbursement for these expenses from this spending account, and have not and will not receive reimbursement for these expenses from any other plan. I understand that expenses reimbursed under the Health Care Spending Account cannot be used to claim a deduction or tax credit on my personal income tax.

_____ Date
Participant's Signature

For Trust Administrative Office Use Only

Date Received: _____ Initial: _____ Date Processed: _____ Initial: _____

CLAIM INSTRUCTIONS

- Complete all sections of this form.
- Attach the following documents:
 - ✓ The Explanation of Benefits form (EOB) issued by an insurance company or claim administrator that shows uncovered health care expenses and the reason why the claim was not paid or not paid in full.
 - ✓ If an EOB is not provided (for vision and Rx claims, or if the expense is not covered by your plan), provide itemized bills which include the patient's name, date of service, type of service, and any plan payments.
 - ✓ Cancelled checks alone cannot be accepted as documentation of expenses.
 - ✓ Please retain a copy of this form and all documentation for your records. Originals will not be returned.

Mail completed form and original documentation to:

Zenith Administrators, Inc.
FSA Department
P.O. Box 91082
Seattle, WA 98111-9182

REIMBURSABLE HEALTH CARE EXPENSES

This is a partial list of eligible expenses. A full list is available in IRS Section #213.

Acupuncture – to treat a medical condition

Ambulance

Birth Control Pills

Car Modifications for Physically Handicapped Person

Chemical Dependency - at a treatment center

Chiropractors - for services within scope of license

Contact Lenses - including contact lens solutions and enzyme cleaner

Crutches - purchase or rental

Deductibles and Coinsurance - not paid by the plan

Dental Fees - x-rays, fillings, braces, extractions, false teeth, treatments, etc.

Drugs and Medicines - prescriptions and over-the-counter drugs used to treat a medical condition

Exercise Equipment – if prescribed by a physician to treat a specific medical condition

Eye Examinations and Eyeglasses

Flu Shots

Guide Dog - purchase for blind or deaf

Insulin

Laboratory Fees

Language Training for Child with Dyslexia or Disabled Child

Laser Eye Surgery

Learning Disability - tutoring by licensed school or therapist

Medical Monitoring and Testing Devices – blood pressure monitor, syringes, glucose kit, etc.

Medicines – legally obtained drugs and medicines used to treat a medical condition with a doctor's prescription after January 1st 2011

Nursing Service – amounts spent in wages and other nursing services

Optometrist - for services within scope of license

Orthodontia

Ovulation Monitor

Oxygen

Physical Exams (not employment-related physicals)

Physical Therapy

Psychiatric Care

Psychologist - for services within scope of license

Radial Keratotomy

Smoking Cessation Programs

Sterilization

Surgery

Vitamins and Mineral Supplements – only if used to treat a specific medical condition

Wheelchairs

X-ray Fees

NOTE: cosmetic surgery or procedures (such as tooth bleaching) and insurance premiums are not eligible expenses.

CONTACT INFORMATION

- You may check your FSA account balance and claims history at any time on our web site at www.zenithfsa.com or by using our integrated voice response Flex Hotline at 1-866-206-2345. If you need personalized assistance, contact our FSA Department at 1-800-757-0071, option 2.