



A UnitedHealthCare Company

Mail or Fax claims to:

UMR

P. O. BOX 690224

SAN ANTONIO, TX 78269-0224

FAX: (866) 868-8904 ATTN: FLEX CLAIMS

EMAIL: BPL-flexclaims@umr.com

**FLEXIBLE SPENDING PLAN  
CLAIM REQUEST FORM**

Please type or print clearly - Completed form must be mailed intact with attached appropriate forms. SEE REVERSE SIDE FOR ADDITIONAL INFORMATION AND REQUIREMENTS.

|                            |                                     |                                 |
|----------------------------|-------------------------------------|---------------------------------|
| EMPLOYEE'S NAME            | SOC SEC # OR EMPLOYEE'S ORACLE ID # | GROUP # OR EMPLOYER'S NAME      |
|                            |                                     | 240104                          |
| EMPLOYEE'S MAILING ADDRESS |                                     | EMPLOYEE'S DAYTIME PHONE NUMBER |
|                            |                                     | ( ) -                           |

**HEALTH CARE EXPENSE REIMBURSEMENT REQUEST**

**Proof of expenses must be attached.** You must submit an itemized statement from the provider showing the name and address of the service provider, the date services were performed, type of service(s) and amount(s) charged. If the eligible expense(s) are covered by another medical, dental or vision plan, you may submit the Explanation of Benefits, which details amounts paid and not paid by the benefit plan as proof of expense(s). *Per Federal Regulations, all available insurance benefits must be utilized before you can claim expenses from your Health Care Spending Account.*

| Date Incurred                              | Name of Service Provider or Description of Expense | Name of Eligible Dependent or "Self" | Relationship or "Self" | Eligible Expense |
|--|--|--------------------------------------|------------------------|------------------|
|  |  |                                      |                        | \$               |
|  |  |                                      |                        | \$               |
|  |  |                                      |                        | \$               |
| <b>Total Eligible Health Care Expenses</b> |  |                                      |                        | \$               |

I certify that I am familiar with and understand the Plan requirements contained in the Summary Plan Description; that the amounts herein requested for reimbursement have actually been incurred as eligible Plan expenses during the Plan Year and that these expenses have not, cannot and will not be reimbursed to me in any other form, be deducted on my income tax return, nor were they previously submitted for reimbursement under this or any other plan.

|                      |      |
|----------------------|------|
| EMPLOYEE'S SIGNATURE | DATE |
|                      |      |

**DEPENDENT DAY CARE EXPENSE REIMBURSEMENT REQUEST**

**Proof of expenses must be attached** and must include dates of services, the provider's employer identification or social security number, and the address of the provider.

| Date or Period Incurred                       | Name and Address Of Provider | Provider's Taxpayer Identification Number | Name/Age of Qualified Dependent | Relationship | Eligible Expense |
|---|------------------------------|---|---------------------------------|--------------|------------------|
|   |                              |   |                                 |              | \$               |
|   |                              |   |                                 |              | \$               |
| <b>Total Eligible Dependent Care Expenses</b> |                              |   |                                 |              | \$               |

I certify that I am familiar with and understand the Plan requirements contained in the Summary Plan Description; that the amounts herein requested for reimbursement have actually been incurred as eligible Plan expenses during the Plan Year; and that these expenses have not, cannot and will not be reimbursed to me in any other form, be used to calculate a tax credit on my income tax return, nor were they previously submitted for reimbursement under this or any other plan.

|                      |      |
|----------------------|------|
| EMPLOYEE'S SIGNATURE | DATE |
|                      |      |

**PARTIAL LISTING OF ELIGIBLE MEDICAL EXPENSES**

|   |   |  |
|---|---|--|
| <p><b>GENERAL MEDICAL EXPENSES</b></p> <p>Abdominal Supports, if prescribed<br/>         Abortion Services, if legal<br/>         Acupuncture<br/>         Ambulance Hire<br/>         Air Conditioner for Allergy Relief (if prescribed by Doctor - cannot be central air conditioning)<br/>         Anesthesia<br/>         Arches<br/>         Artificial Limbs/Prosthesis<br/>         Alcoholism<br/>         Back Supports<br/>         Birth Control Pills (if prescribed by a Doctor)<br/>         Blood Donor Expenses<br/>         Braces/Orthodontist**<br/>         Braille Books/Magazines (only the value above the regular price of the publication)<br/>         Car Controls for Handicapped<br/>         Chiropractic Services<br/>         Chiropractic Services<br/>         Christian Science Practitioner Services<br/>         Convalescent Home Expense (Medical Treatment Only - not Custodial Care)<br/>         Cosmetic Surgery necessary to correct a deformity due to congenital abnormality or one caused by personal injury or disfiguring disease<br/>         Cost of Operations and related treatments<br/>         Co-payments you pay<br/>         Crutches<br/>         Deductibles<br/>         Dermatologist Fees<br/>         Diathermy<br/>         Doctors Office Visits<br/>         Drug Treatment<br/>         Fertilization Services<br/>         Gynecological Exams<br/>         Hospital Bills<br/>         Hypnosis Hydrotherapy<br/>         Immunizations<br/>         Insulin</p> | <p>Invalid Chair and Other Supplies<br/>         s for treatment of illness<br/>         Kidney Donor Expenses<br/>         Lab Expenses<br/>         Laetrile by Prescription<br/>         Lip Reading Lessons<br/>         Medical Equipment /Supplies<br/>         Midwife Expense<br/>         Neurologist Fees<br/>         Non-prescription over the counter drugs used to treat or alleviate personal injury or sickness. (as allowed by your plan doc - effective date of allowed reimbursement based on plan doc)<br/>         Nurses Fee (including Room and Board Charges) *<br/>         Nursing Home Expenses *<br/>         Nursing Care *<br/>         * - If necessary for medical care<br/>         Obstetrician Fees (upon delivery and born within same Plan Year)<br/>         Orthopedic Shoes<br/>         Osteopath<br/>         Oxygen<br/>         Pediatrician Fees<br/>         Physical Therapy<br/>         Physician Fees<br/>         Physical Exams<br/>         Podiatrist<br/>         Practical Nurse for Medical Care<br/>         Prescription Drugs (**Drug name required**)<br/>         Psychiatric Care<br/>         Psychologist<br/>         Psychotherapist<br/>         Reclining Chair with Prescription from Physician<br/>         Rental of Medical Equipment<br/>         Remedial Reading for Dyslexia<br/>         Sacroiliac Belt<br/>         Sanitarium<br/>         "Seeing-eye" dog and its upkeep<br/>         Sex Therapy - if received as medical treatment<br/>         Smoking Cessation Program (including stop smoking drugs by prescription)<br/>         Special Diets if not a substitute for regular diet</p> | <p>Special Education for the Blind<br/>         Sterilization Fees<br/>         Support or Corrective Devices<br/>         Surgeon Fees<br/>         Therapeutic Care for drug and alcohol abuse<br/>         Therapy Treatments<br/>         Transportation and Lodging Expenses if paid primarily for and essential to medical care<br/>         Transplants<br/>         Truss<br/>         Vasectomy<br/>         Vitamins (by prescription)<br/>         Well Baby Care<br/>         Wheelchair<br/>         Wigs (prescribed by doctor for hair loss by disease)<br/>         Whirlpool baths if Prescribed by doctor and does not increase the value of the residence<br/>         X-rays</p> <p align="center"><b>DENTAL EXPENSES</b></p> <p>Bridges, Crowns, Dentures, Exams, Fillings, Orthodontia, X-rays, Insurance Deductible, Co-payments you pay</p> <p align="center"><b>HEARING EXPENSES</b></p> <p>Exams, Hearing Devices and Aids (including batteries)<br/>         Special Communication Equipment for the Deaf</p> <p align="center"><b>VISION CARE</b></p> <p>Exams, Contact Lenses , Frames, Lenses, Solutions, Oculist services, Optician services, Optometrist services<br/>         Radial keratotomy, Lasik Eye Surgery</p> <p align="center"><b>OTHER HEALTH CARE EXPENSES</b></p> <p>Special Schools for handicapped persons - must have specific programs to deal with handicapped.<br/>         Special home modifications for handicapped; cannot increase value of the home.<br/>         Life fee to retirement home for medical care - contract must allocate an amount to medical fees.<br/>         Membership fees in association furnishing medical Services, hospitalization and clinical care.</p> |
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**PARTIAL LISTING OF NON-ELIGIBLE MEDICAL EXPENSES**

|   |  |  |
|---|--|--|
| <p>Bottled water<br/>         Cosmetics, toiletries, tooth paste, teeth bleaching, etc.<br/>         Custodial care in an institution<br/>         Funeral and burial expenses<br/>         Health club dues, YMCA dues, steam bath, etc. for purposes of general health and well being, even if prescribed by a physician<br/>         Household and domestic help (even though recommended by a qualified physician because of an employee's or dependent's inability to perform physical housework)<br/>         Insurance premiums are not reimbursable<br/>         Marriage or family counseling<br/>         Maternity clothes, diaper service, etc.<br/>         Membership fees of costs associated with weight loss or smoking cessation programs for purposes of general health and well being, even if prescribed by a physician<br/>         Non-prescription drugs used for general good health. (see vitamins / supplements)</p> | <p>Nursing for newborns: the salary expense of a licensed practical nurse incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth)<br/>         Operations: any expense incurred in connection with an illegal operation or treatment<br/>         Premiums: any medical or dental insurance premiums, automobile insurance premiums including the segment of premiums providing medical coverage for persons injured through accident by an employees car-any life insurance premiums paid for life insurance policies or for policies providing repayment for loss of earnings or accidental loss of life, limb, sight, Etc.<br/>         Social activities, such as dance lesson or classes even though recommended by a qualified physician for general health improvement.</p> | <p>Special schools: any expenses incurred for sending a problem child to a special school for anticipated benefits the child may receive from the course of study and the disciplinary method used<br/>         Transportation expense to and from work, even though a physical condition may require special means of transportation.<br/>         Uniforms<br/>         Unnecessary cosmetic surgery, such as a face lift<br/>         Vacations for travel taken for purposes of general health, change in environment, improvement of morale, etc., to relieve physical or mental discomfort not related to a particular disease or physical defect<br/>         Vitamins or supplements taken for general health purposes<br/>         Weight loss and related charges, unless prescribed by a physician to treat medical illness(e.g., heart disease, diabetes).</p> |
|---|--|--|

**TRANSPORTATION - YOU MAY INCLUDE** as medical expenses amounts paid for transportation primarily for and essential to medical care at the current IRS rate. **YOU MAY NOT INCLUDE** transportation expenses to and from work, even if your condition requires an unusual means of transportation or transportation expenses for non medical reasons.

**BRACES/ORTHODONTIST** – We cannot accept a claim for the entire contracted amount. We will accept claims for the initial down payment usually associated with the appliance. Monthly payments will also be accepted as the charge of the dental services rendered for that month. We will need a copy of the orthodontia contract for your file.

**LODGING - YOU MAY INCLUDE** in medical expenses the cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive medical care. The amount you include in medical expenses may not exceed \$50.00 a night for each individual. Lodging expense is eligible for a person who must accompany the individual receiving medical care, for example, a parent traveling with a sick child. **YOU MAY INCLUDE** in medical expenses the cost of lodging (not provided in a hospital or similar institution) while away from home **IF** the lodging is primarily for and essential to medical care provided by a doctor in a licensed hospital or equivalent and there is no significant element of personal pleasure.

**IMPORTANT: CONSULT IRS PUBLICATION 502 FOR A MORE COMPLETE LISTING OF ELIGIBLE AND NON-ELIGIBLE MEDICAL EXPENSES**

\*\*\*\*PLEASE NOTE: IRS PUBLICATION 502 IS A GUIDE – NOT ALL EXPENSES LISTED ARE REIMBURSABLE THROUGH YOUR FLEX PLAN..\*\*\*\*

\*\*\*\*\*FOR QUESTIONS OR ADDITIONAL INFORMATION, PLEASE CONTACT THE FLEX DEPARTMENT DIRECTLY AT 866/308-8230\*\*\*\*\*

**DEPENDENT CARE - IMPORTANT RESTRICTIONS**

If married, the total payments made in a taxable year, under this and any other Dependent Care Plan, cannot exceed the lesser of your earned income, or your spouse's earned income, during that taxable year. – The expenses are necessary to enable you (and your spouse, if married) to work or actively search for employment. - Your spouse must work outside the home, be a full-time student or be disabled. – Your dependent must be under the age of 13 and must be eligible to be claimed as a dependent on your federal income tax return, or your dependent is physically or mentally incapable of caring for himself or herself ( a disabled spouse or elderly parent, for example). - If services were provided outside the home, the dependent for whom services were incurred spends at least (8) hours a day in your household. - The person providing the service will not be claimed as a dependent on your income tax return for the Plan Year in which the service was provided.

**CONSULT IRS PUBLICATION 503 FOR ADDITIONAL GUIDANCE.**