SEND Pacific Benefit Consultants, Inc. 3090 Fite Circle, Ste. 201 **OR** Sacramento, CA 95827-1810 **FAX TO** (916) 363-2117	**Call us at**: (800) 800-2090 or (916) 363-2101 **Web Site:** www.pacificbenefits.com	Call **FLEX VOICE** to check that your Voucher was received 72 hours after sending & to check your balance at (916) 361-6955 or (800) 838- 4511

Please read the reverse prior to filling out voucher

CLAIM FOR REIMBURSEMENT ***VOUCHER***

NAME: ____ ADDRESS: ____

☐ **check here if new address**

CITY: ______________________________ STATE: _______ ZIP: _____________WORK PHONE: _____________________

SOCIAL SECURITY NO. ______________________________ **EMPLOYER: ___________________________________**

EMAIL ADDRESS____

READ CAREFULLY: The information below is a true and accurate statement of the unreimbursed expenses incurred by me and/or my eligible dependents (does not include domestic partners unless they qualify as a dependent on you tax return) on the dates indicated, and were incurred while I was covered under the Company's Cafeteria Plan. I have submitted any health care expenses covered by other insurance plans to those plans, but payment has been denied in part or in full as shown on the attached form. Receipts from all service providers for all expenses claimed are attached to this voucher. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I alone am personally liable for payment of any related taxes and penalties (FICA, Federal, State, SDI, etc.) that might be assessed on the amounts paid for any expense improperly claimed on this form. **I understand that I can be reimbursed for only IRS allowed medical expenses as described in the Cafeteria Plan enrollment material and I affirm that the expenses on this form are for treatment of a specific illness or condition and not just for my general health.**

EMPLOYEE SIGNATURE: ____ DATE: ___________________

IF THE UPPER SECTION OF THIS VOUCHER IS NOT COMPLETED *IN FULL*, IT WILL BE RETURNED TO YOU FOR COMPLETION *WITHOUT* BEING REIMBURSED.

DEPENDENT CARE EXPENSE CLAIMS: **ALWAYS REMEMBER TO FILE IRS FORM 2441 AT CALENDAR YEAR END **

Name of Dependent	Age	Begin Date	End Date	Claim Amount
				$
				$
				$
TOTAL DEPENDENT CARE EXPENSE CLAIM				$

DEPENDENT CARE RECEIPT

Received $ __________ from ________________

For dep. care from ____________ to ___________

Service Provider

Name____________________________________

Address__________________________________

City________________ State______Zip__________

Taxpayer I.D./S.S.N. _______________________

Service Provider Signature_____________________

UNREIMBURSED HEALTH CARE EXPENSES: (Feel free to use a separate page to list additional expenses) ***Please provide an EOB from your Ins. carrier and/or copies of written statements/documentation from your service provider (We cannot accept credit card receipts or copies of cancelled checks), which includes the type of service and the following:***

Name of Person Covered	Date of Service	Service Provider Name and Address	Roundtrip Mileage	Net Claim Amount
				$
				$
				$
				$
PLEASE CALCULATE TOTAL ROUNDTRIP MILEAGE:			[ ] x .1_[1] =	$
TOTAL HEALTH CARE EXPENSE CLAIM				$

INDIVIDUALLY OWNED HEALTH INSURANCE POLICIES: ****Please note that only health insurance policies owned by the employee or dependents are covered; *not life insurance policies nor spouse's group insurance or long-term care policies* ****

Name of Person Covered	Insurance Company Name	Period of coverage	Premium Paid
			$
			$
TOTAL INSURANCE EXPENSE PAID			$

Mileage Rates: 2007=**$.20** per mile. January 1-June 30, 2008=**$.19** per mile. July 1-December 31, 2008=**$.27** per mile.

ACCOUNT RULES AND CLAIM FILING

RULES FOR BOTH DEPENDENT CARE
AND
UNREIMBURSED HEALTH CARE SPENDING ACCOUNTS

- Only employees participating in the Cafeteria Plan can submit a voucher.
- $25.00 minimum reimbursement until amount available for the plan year is less than $25.00
- Employees can submit a voucher at anytime during the plan year and for a specified time (the Claim Rollout Period following the end of the plan year) as described in the Summary Plan Description.
- Terminated employees can submit a voucher for expenses incurred, while an active plan participant, up to Claim Rollout Period after the end of the plan year.
- Reimbursements can only be made for eligible expenses incurred during the current plan year.
- IRS rules stipulate that any money left in your account(s), after all reimbursements for the plan year have been processed, cannot be carried forward or returned. Money in one account cannot be used for expenses incurred in another account.
- You cannot receive payment from any other source for expenses reimbursed by a voucher, and you must certify that you are not eligible to bill any other source for the expenses.
- Attach copies of receipts from service providers, statements from providers reflecting the amount you are responsible for, or an explanation of benefits form from insurance carriers to the voucher. **Do not attach cancelled checks or credit card receipts.**
- Sign and date the voucher.
- Make a photocopy of the voucher and receipts for your records.
- Submit your voucher, with the attached receipts, to the administrator according to the procedures provided by your employer. Vouchers are available from the Human Resources Department.
- Refer to your Summary Description and Plan Brochure for eligible expenses.

DEPENDENT CARE EXPENSES

- You can use a dependent care expense account only if you pay dependent care expenses ***in order to be able to work***. Refer to your Summary Plan Description for eligible expenses. Your daycare services can take place either in or outside of your home. If you are married, ***your spouse must also work***, go to school full time, or be incapable of self-care for you to be eligible. **Once a child enters k*indergarten, tuition is not an allowable IRS Dependent Care Expense.***
- Only (a) dependents under the age of thirteen or (b) dependent adults or children thirteen years or older who are mentally or physically incapable of self-care are covered.
- Your maximum contribution amount cannot be more than the smaller of (a) or (b).

A: Your income or your spouse's, whichever is smaller. (If your spouse is a full-time student or incapable of self- care, the IRS views your spouse as earning: $3,000.00 per year with (one) dependent or $6,000.00 per year with (two) or more dependents.)

-or-

B: $5,000.00 per year if your tax filing status is "single", "married filing jointly", or "head of household"; $2,500.00 per year if your tax filing status is "married filing separately".

- To be reimbursed, you must include the facility/provider name, address and tax identification number or the social security number, name, and address of the individual providing the dependent daycare service.

- The maximum amount you can be reimbursed, during the time you are covered in the plan year, cannot exceed the salary reduction amounts you have elected and made to the dependent care expense account less any previous reimbursements paid.