

# IPG FLEX PLAN REIMBURSEMENT CLAIM VOUCHER

EMPLOYEE NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PLAN YEAR: \_\_\_\_\_

Please read the Instructions on the back of this form and the FSA Rules in your SPD before completing this voucher.

**MEDICAL REIMBURSEMENT ACCOUNT CLAIMS**

Name of Person Service Covers	Date Service Performed	Description of Service including Name of Service Provider	Net Claim Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

**TOTAL MEDICAL REIMBURSEMENT CLAIM \$ \_\_\_\_\_**

**DEPENDENT CARE ACCOUNT CLAIMS:**

Name of Dependent(s)	Dates of Service	Service Provider Name and Address with Taxpayer ID Number	Claim Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

**TOTAL DEPENDENT CARE CLAIM \$ \_\_\_\_\_**

**Please Read Carefully**

I request payment for these expenses from my flexible spending account(s). I certify that the above information is a true and accurate statement of unreimbursed expenses incurred by **me or my eligible dependents** on the date(s) indicated, and were incurred while I was covered under my employer's Plan. These expenses have not been nor will ever be reimbursed by another source or claimed on my personal income tax return. I understand that I may be liable for payment of all related taxes including Federal, State and/or City income tax on the amounts paid for any expense improperly claimed under the Plan.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Email:** \_\_\_\_\_

# INSTRUCTIONS

## ACCOUNT RULES AND CLAIM FILINGS:

- Only employees participating in the Plan may submit a claim voucher.
- Employees can submit a voucher at any time during the plan year and for a specified grace period after the plan year as described in their Plan's Summary Plan Description.
- Terminated employees can submit a voucher for a specified grace period after the date of termination as stated in their Plan's Summary Plan Description.
- Reimbursements can only be made for eligible expenses incurred during the coverage period in which your contributions were made.
  
- IRS rules stipulate that any money left over 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 to cover expenses incurred in another account. For instance, any unused amounts left in the medical reimbursement account cannot be used to reimburse dependent care expenses.
- You cannot claim for a service period that begins in one plan year and ends in the next plan year. Two separate claim vouchers will need to be submitted; one for each plan year covering the period of service during that plan year.
- The maximum amount available to you in a Dependent Care FSA at any time is only the amount currently in the account.
- Documentation supplied for processing will not be returned. Use photocopies when possible.
- **Claims cannot be processed unless ALL of the information on the voucher is completed.**
- Copies of receipts from service providers and/or the Explanation of Benefits Form from Insurance Carriers may each qualify as substantiation.
  
- **SIGN AND DATE THE VOUCHER.**
- Substantiation must include an independent third-party statement containing all information on the Claim Voucher.
- Canceled checks **alone** are not sufficient to document medical reimbursement claims.
- **Claim eligibility is considered based on the *dates of service* not *dates of payment*.**
- Handwritten receipts for dependent care are acceptable as documentation.
- Payments will only be made directly to you.
- **MAIL OR FAX COMPLETED FORM TO:**



Employee Benefits  
*specialists*