JRM Benefit Administrators, LLC

Attn: Claims Department
PO Box 277
Onalaska, WI 54650
Phone: (608) 781-8712
Claims Fax: (608) 781-8713

FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT CLAIM FORM

⇨Reminder: *Read the instructions on the reverse side of the claim form before completing.*
To expedite your claim, please provide ALL appropriate information showing the date and description of service.

Social Security Number	**Daytime Phone Number**
Last Name	**First Name**
Employer Name	
Email Address	
☐ **Change of Address:**	

Grace Period Plan Participants

- ➡ Funds from the prior year's plan will be reimbursed first then current plan will be reimbursed.
- ➡ Please contact our office if funds need to be reimbursed differently.

Unreimbursed Medical Expense Claims ➲ Do not lump line items together, services must be itemized.

Date of Service	Name of Service Provider	Description of Service (Deductible, Vision, Dental, OTC, Rx)	Name of Covered Dependant	Relationship to Employee	Net Amount	Office Use Only

✓Attach appropriate receipt(s) and submit with this claim form. Total FSA Claim:

Dependant Care Expenses ➲ Do not lump line items together, services must be itemized.

Name of Covered Participant / Dependant(s)	Period Covered From	Period Covered To	Net Amount	Provider of Service		Office Use Only
				Name*		
				Address		
				Taxpayer Identification Number of Provider of Service :		
✓Attach a receipt from your daycare provider or include the daycare provider's signature.		Total*		Providers' Signature:		

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependant, or $500 if there are two (2) or more.) No payment may be under the Plan; if the service provider is your dependent for federal income tax purpose; or is your child or stepchild and is under the age 19.

Read Carefully: The undersigned participant in the Plan certifies that for all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

***Employee Signature** is* **required** *to process this claim. Spouse or dependant cannot sign claim form.*

Employee's Signature _____ **Date** _____

Office Use Only

Date Received _____

Notes _____

Instructions and Helpful Hints

General Information

- Submit your completed claim form and attached documentation to: JRM Benefit Administrators, LLC, Attn: Claims Dept, PO Box 277, Onalaska, WI 54650 or fax to (608) 781-8713. When faxing please do not follow-up with a hard copy in the mail.
- If you have not received any correspondence (reimbursement check, direct deposit, letter, and/or email) or a telephone call from us after ten (10) days from submitting your claim please contact our office with questions at (608) 781-8712.

Employee Profile

- Please fill in *ALL* the requested information. Remember to print your information so we can process your claim accurately.

Website

- To access the Web site go to: www.repayme.com/admin/default.asp?cn=JJAI or www.jrmcpa.biz and select "links" on the left side of the screen and then select "JRM Benefit Administrators - participant login" from the list.
- For first time users follow these steps: At the login screen enter: "Login ID" (your social security number), "PIN" (last 4 digits of social security number), "Login Method Using" (select social security number). Note: with your first login, you will be prompted to change your PIN. After completing the questions and selecting "change PIN" you will be able to view your account and submit claims.
- When you are done viewing your account select "Logout".

Unreimbursed Medical Expense Claims

- Please fill in *ALL* of the fields. This information is required and must be filled in for your claim to be processed.
- Provide a copy of the Explanation of Benefits (EOB) from your insurance company for qualified expenses (if available).
- When attaching a copy of an itemized statement as proof for qualified expense, the itemized statement *must* contain the following information: **1.** name and address of the provider, **2.** patient's name, **3.** date of service (date service was provided, not the date service was paid for), **4.** description of services provided, and **5.** itemized charges.
- If you are submitting a claim for a prescription drug, the receipt provided by the pharmacist must be submitted which contains the following information: **1.** name of the provider, **2.** patient's name, **3.** date of service (date service was provided, not the date service was paid for), **4.** prescribing physician, and **5.** prescription dollar amount.
- Cancelled checks, credit card receipts, or statements detailing only a balance due **ARE NOT** considered acceptable documentation for reimbursement.
- Orthodontia claims require the following documentation: **1.** an itemized statement and **2.** the orthodontics' contract agreement showing the monthly payment.
- For qualified over-the-counter expenses, you must submit evidence of the purchase date and the specific medicine and/or drug name. **Vitamins, supplements, herbal remedies, and hygienic products are not qualified expenses and cannot be reimbursed through your FSA Plan.** If your physician diagnoses a specific medical condition and the product is medically necessary to treat that condition you may submit the product for reimbursement with a letter from your physician detailing the required explanations above.
- If faxing your claim, *do not highlight the medical expense* because the item is blacked out on the receiving fax.
- Do not highlight the medical expense on cash register receipts because the item becomes faded and/or blacked out.
- Please list each expense individually on the claim form, do not lump items together. Listing out each expense speeds up the claim processing procedure and you will receive your reimbursement sooner.
- Only submit copies of receipts, itemized statements, etc. You should keep all originals, including receipts for your personal records.

Dependant Care Expenses

- Please fill in *ALL* of the fields. This information is required and must be filled in for your claim to be processed.
- The service(s) you are submitting a claim for *must have occurred. We cannot reimburse payments for future dates of service.*
- Provide a copy of a receipt or statement from the provider of the service with this form **ONLY IF the provider does not sign the claim form with their tax identification number or Social Security Number.**
- The receipt/statement submitted with this claim form must include the following information: **1.** name of the provider, **2.** address of the provider, and **3.** the provider's tax identification number or Social Security Number if your provider does not have a tax identification number.
- If there is not enough money in your Dependant Care Flexible Spending Account to pay the entire amount of the claim you submit, the claim will be paid up to the amount currently available in your account. You will not need to resubmit this claim again to receive full reimbursement. As more money accumulates in your account, you will automatically be reimbursed up to the full amount of the claim.

Employee Signature

- Be sure to sign and date this claim form before submitting it for reimbursement. We cannot process your claim with this part missing.
- The **employee** can only sign this claim form; spouse or dependant **CANNOT** sign this form.