PAYCHEX

REIMBURSEMENT CLAIM
FLEXIBLE SPENDING ACCOUNT

EMPLOYEE INFORMATION (please print) Office/Client Number Y275 ___ ___ / ___ ___ ___ ___

Company Name Somerset Home for Temporarily Displaced Children Employee Phone Number (___) _____

Employee Name _____ Social Security Number _____ - _____ - _____

Address _____ City _____ State _____ Zip Code _____

CLAIM INFORMATION

Claim Ref.	Member Name	Relationship to Employee*	Date(s) Service Performed	Description	Provider of Service	Amount	Type Account
01							M/C
02							M/C
03							M/C
04							M/C
05							M/C
06							M/C
07							M/C
08							M/C
					TOTAL		

* Self/Spouse/Child/Other *(Specify)*

I certify that the information here is true and correct, that the expenses incurred were for myself, spouse, or dependents, and that these expenses are not reimbursable under any other health plan coverage.

_____ _____

EMPLOYEE SIGNATURE DATE

REMINDERS:

- Claim payment checks are processed on a weekly basis. Claim forms must be received by Paychex by noon ET on Friday for reimbursement checks to be processed the following Wednesday.
- Enclose a copy of **all bills** for reimbursement.
- Verify that bills contain the date and description of service, the amount, and the provider's name stamped on receipt. Dependent care bills must include the provider's Federal ID or social security number.
- Claims must exceed $25.00 before a reimbursement check will be processed.
- Enclose a copy of the orthodontist contract for first time orthodontia claims.
- **Sign your claim form**, and retain a copy for your records.

MAIL TO:
Paychex Inc.
Section 125 Department
FSA Claims
1175 John Street
West Henrietta, NY14586
Fax: 585-654-3205

If you have any questions, contact the Paychex Section 125 Department: 1-800-472-0072

PAYCHEX

MONTHLY DEPENDENT CARE CLAIM
FLEXIBLE SPENDING ACCOUNT

EMPLOYEE INFORMATION *(please print)*

Office/Client Number Y275 ___ ___ / ___ ___ ___ ___

Company Name Somerset Home for Temporarily Displaced Children

Employee Phone Number (___) _____

Employee Name _____

Social Security Number _____ - _____ - _____

Address _____ City _____ State _____ Zip Code _____

CLAIM INFORMATION

	Date	Weekly Amount
Week 1	____ / ____ / ____ to ____ / ____ / ____	$_____
Week 2	____ / ____ / ____ to ____ / ____ / ____	$_____
Week 3	____ / ____ / ____ to ____ / ____ / ____	$_____
Week 4	____ / ____ / ____ to ____ / ____ / ____	$_____
Week 5	____ / ____ / ____ to ____ / ____ / ____	$_____
	Total Monthly Amount	**$**_____

I certify that the information contained herein is true and correct, that the expenses incurred were for my eligible dependent(s) and that these expenses are not reimbursable under any other source.

_____ EMPLOYEE SIGNATURE

_____ DATE

CERTIFICATION FROM PROVIDER

We certify that we are providing Dependent Care Services for the above employee for the

month of _____ in the year of _____ for _____ CHILD'S NAME

Name of Day Care Provider: _____

Federal ID or Social Security Number: _____

_____ SIGNATURE OF DAY CARE PROVIDER

_____ DATE

REMINDERS:

- Claim reimbursements are processed on a weekly basis. Claim forms must be received by Paychex by noon ET on Friday for reimbursements to be processed the following Wednesday.
- Dependent Care claims will be reimbursed to the participant up to the balance available in the account.
- Claims must exceed $25.00 before a reimbursement will be processed.
- Provider's Federal ID or social security number MUST be provided.
- **Sign your claim form**, and retain a copy for your records.

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Section 125 Department
FSA Claims
1175 John Street
West Henrietta, NY 14586
Fax: 585-654-3205

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PAYCHEX®

Election Form/Compensation Reduction Agreement Flexible Spending Account

EMPLOYEE INFORMATION *(please print)* Office/Client Number Y275 ___ ___ / ___ ___ ___ ___

Company Name Somerset Home for Temporarily Displaced Children Employee Phone Number (___) _____

Employee Name _____ Social Security Number _____ - _____ - _____

Address _____ City _____ State _____ Zip Code _____

SELECT ONE

☐ **NEW ENROLLMENT** (Annual Enrollment or Eligible New Hire) - Date of Hire ____/____/____

☐ Annual Medical/Dental Election $ _____ ☐ Annual Dependent Care Election $ _____ Maximum $5000.00

Note: To calculate your pay period amount, divide your annual amount by the number of pay periods.

☐ **CHANGE IN STATUS** - Date of Event ____/____/____

Note: The plan effective date is the next pay period following the event date. * These changes are allowable only if eligibility is affected.

- ☐ Dependent care cost provider changes
- ☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements
- ☐ Birth/Death of spouse or dependent, adoption or placement for adoption
- ☐ Spouse's employment commenced/terminated
- ☐ Status change from full-time to part-time or vice versa by employee or spouse*
- ☐ Eligibility or Ineligibility of Medicare/Medicaid
- ☐ Change from salaried to hourly or vice versa*
- ☐ Marriage/Divorce/Legal Separation
- ☐ Unpaid leave of absence by employee or spouse
- ☐ Return from unpaid leave of absence by employee or spouse

New Annual Elections

☐ Annual Medical/Dental Election $ _____ ☐ Annual Dependent Care Election $ _____ Maximum $5000.00

Note: To calculate your pay period amount, divide your annual amount by the number of pay periods.

☐ **TERMINATION** - Date of Event ____/____/____

AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year beginning ____/____/____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. As a participant I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

- ❖ If I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election already in effect for the new plan year.
- ❖ I cannot change or revoke this agreement at any date prior to the next plan year unless I have a change in status as set forth under the Plan. Prior to my next plan year I will be offered the opportunity to change my benefit election for the following year.
- ❖ My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated.
- ❖ The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.
- ❖ The amount of my compensation reduction will be credited to the appropriate reimbursement account held by the Employer for payment of eligible expenses incurred within the plan year.
- ❖ The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- ❖ Reimbursement will be available only for qualifying expenses as described in the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- ❖ If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount.

Employee Signature _____ Date ____/____/____

Employer Signature _____ Date ____/____/____

MAIL OR FAX TO

Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: (585) 654-3205

Note: If Change in Status has occurred, supporting documentation must be submitted to the Employer within 30 days of the event.