

UNIVERSITY OF DENVER

Flexible Spending Account Reimbursement Form Instructions

To speed processing of your flexible spending account form, please be sure to supply the following information for each covered expense using the attached form. Please include originals or copies of receipts with the claim form.

Return to: Benefits & Incentives Group, Inc.
1777 S. Harrison Street, Suite 700
Denver, CO 80210
Phone (303) 750-6200 x26
Fax (303) 750-6300
Attention: Janna Dyer

- Medical, dental, and vision expenses covered under any benefit plan should be submitted to the appropriate insurance companies before applying to the Flexible Spending Account. The resulting explanation of benefits (EOB) should accompany this claim form.
- Print the name of the person receiving the service, the type of services or supplies furnished, the name of the supplier, the amount charged, the amount paid by the insurance plan, and the date the service was rendered. (*Your claim may be delayed, if this information is not provided.*)
- Proper documentation certifying all services or charges should be retained by the employee to support all requests for reimbursement. Copies of such documentation (paid receipts or vouchers) should accompany this form.
- For Dependent Care expenses list the name, address, and tax I.D. number (Social Security #) of the provider.
- The IRS stipulates that paying for Dependent Care on a pre-tax basis is legitimate only if it allows you and/or your spouse to be gainfully employed, to be seeking gainful employment, or to attend school on a full-time basis.
- Eligible dependents include:
 - a) a dependent child under the age of 13 for whom the employee is entitled to a tax deduction; or
 - b) a spouse or other dependent who is physically or mentally incapable of caring for him/herself and who lives in the employee's household.

UNIVERSITY OF DENVER
Flexible Spending Account Reimbursement Form
(Please Print)

Employee's Name: <i>(Last, First, MI)</i>	DU ID#:
Address: <i>(Street, City, State)</i>	Zip:
Department:	Extension:
Email Address:	

Expenses may only be submitted if incurred while employed and/or participating in the Flexible Spending Plan

Date of Service	Provider: Doctor, Daycare, Pharmacy, etc.	Type of Service: Office Visit, RX, Dental, Vision, etc.	Services for: List Name & Relationship	Amount	Portion Paid by Insurance	Total Amount to be Reimbursed

Total Submitted for Reimbursement: \$ _____

Be Sure to Attach Applicable Documentation for Each Expense Item

I certify that these qualified expenses were incurred by my eligible dependents, or me as evidenced by the proper documentation. I have not requested reimbursement under this plan or any other source for the above requested amounts. I understand that by claiming these items under the Flexible Spending Account I cannot claim them on my personal income tax (Form 1040). I also certify that I have used all coordination-of-benefit options available to my dependents and me.

I understand that I may only be reimbursed for expenses incurred up to the date of termination. I will not be reimbursed for expenses incurred following that date.

I understand that I may submit expenses for reimbursement incurred before my termination date through the end of the current plan year.

Employee SignatureDate

***Please do not return this form to the DU Benefits Office! Mail or FAX to
Benefits and Incentives Group, 1777 S. Harrison Street, Suite 700, Denver, CO 80210, attn: Janna Dyer
phone (303) 750-6200 x26 fax (303) 750-6300.***