

IBIS 125-Flex Advantage Plan Claim Reimbursement Form

Return to: 105/125 Department
800.258.1415
515.286.4244 fax

Iowa Bankers Insurance & Services, Inc
PO Box 6210
Johnston, IA 50131

Employer Name/Location	Billing/Routing Number
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1. Employee Information:

Employee Last Name	First Name	Initial	Employee Social Security Number
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2. Health Care: An itemized statement is required including date of service, type of service, and total charge.

Date(s) Incurred	Name of Person Receiving Care	Description of Expense	Provider Name (i.e., clinic, doctor, hospital)	Total Expense	Amount Paid by Insurance	Amount Remaining
TOTAL AMOUNT OF MEDICAL EXPENSE				\$	\$	\$

3. Dependent Care: A receipt is required from your daycare provider that includes dates of care and total charge. If you do not have a receipt, the daycare provider must sign the verification section.

Name	Dependent Receiving Care Relationship	Age	Date(s) of Care	Care Provider (Name and Soc. Sec. No./Federal Tax ID)	Amount

DAYCARE PROVIDER VERIFICATION

I certify that the expenses shown are valid.

Signature of Daycare Provider (if receipt not attached) _____ Social Security Number./Federal Tax ID _____ Date _____

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I receive reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical and/or dependent care expenses which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and as outlined on the reverse side of this form.

Employee Signature	Date
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GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

GENERAL INFORMATION:

- Complete all necessary fields on the form. Section 1: Employee Information. Section 2: Limited Scope/General Purpose Health Flex Spending expenses. Section 3: Dependent Care expenses.
- Attach the supporting documents. Keep copies for your records.
Receipts/documentation must show: date of service or purchase, type of service or name of product, total charge, whom service was for
 - Copy of your receipts on an 8 1/2 x 11 sheet of paper.
 - Itemized receipt for over the counter items must show name of product.
(This most often will not show who made the purchase.)
 - Detailed itemized statement from your dental or healthcare provider.
 - Explanation of Benefits (EOB) from your insurance company,
- Submit your form by fax or mail. Deadline is Wednesday at 10:00AM for weekly Friday payment.
- *Please do not: Use red ink, staple copies of your receipts to the request form, or mail a copy of the form you already faxed.*
- Doctors letter or Medical Necessity Form required for the following.

LIMITED SCOPE (DENTAL/VISION ONLY) OR GENERAL PURPOSE HEALTH FLEX SPENDING ACCOUNT

- General Purpose expenses are for valid medical care expenses under IRS Code 213. The expenses qualify as being services or treatments for medical, vision care, dental care or preventative care as described by our plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries.
- Limited Scope expenses are for dental and vision expenses only. This plan is most often used in conjunction with a Health Savings Account.
- These expenses can not be previously reimbursed under the Health FSA or any other plan. Reimbursement must not be sought under the Medical Insurance Plan.
- Expenses may be claimed for yourself, spouse or eligible dependent.
- For a listing of eligible expenses for IRS Code 213, refer to the IRS web site or speak to your employer about the availability of the Health Care Expense Table.

Please note, you may only submit expenses for yourself and your eligible spouse/dependents who qualify under federal law. Expense attributed to same-sex spouses or individuals who do not meet the IRS' definition of "qualified dependent" may not be submitted for reimbursement under this Plan.

DEPENDENT CARE REIMBURSEMENT

- By signing and submitting this DCAP Reimbursement Request Form, you are certifying that expenses you request satisfy the allowable reimbursements listed in the Summary Plan Description.
- Each person for whom a request is made must be a qualifying individual. Please see your Summary Plan Description.
- No reimbursement will be made to the extent that the amount of such reimbursement is larger than the balance remaining in your DCAP account.
- Expenses incurred must be for services incurred after your election date and during the plan year to which the election applies
- Expenses are incurred in order to enable you to be gainfully employed (and your spouse if you are married). The exception is if your spouse is a full-time student, or physically or mentally incapable of self care.
- Expenses must be from a qualified provider
- The IRS will set the plan maximum limits. Please refer to your Summary Plan Description.
- Expenses requested through reimbursement must not be claimed on your personal tax return.

Accepted Over the Counter Items*

Antiseptics, Dressings & Supplies

Adhesive or elastic bandages
 Antiseptic wash or ointment for cuts
 Benzocaine swabs
 Boric Acid powder
 Cold or hot compresses
 First aid wipes
 Gauze and tape
 Gloves and masks
 Hydrogen Peroxide
 Iodine tincture
 Leg or arm braces
 Rubbing Alcohol
 Sublimed Sulfer powder

Asthma Medications

Bronchodilator/Expectorant tablets
 Bronchial asthma inhalers

Cold, Flu, and Allergy Medications

Allergy medications
 Cold relief syrup
 Cold relief tablets
 Cough drops or syrup
 Flu relief tablets or liquid
 Medicated chest rub
 Sinus medications
 Vapor patch cough suppressant

Diabetes

Diabetic lancets
 Diabetic supplies
 Diabetic test strips
 Glucose meters

Ear/Eye Care

Airplane ear protection
 Ear drops for swimmers
 Ear water-drying aid
 Ear wax removal drops
 Contact lens solutions
 Eye Drops

Health Aids

Antifungal treatments
 Denture adhesives
 Diuretics and water pills
 Hemorrhoid relief
 Incontinence supplies
 Medicated bandages
 Motion sickness tablets
 Respiratory stimulant ammonia

Pain Relief

Arthritis pain reliever
 Bunion and blister treatments
 Itch relief
 Orajel
 Pain relievers, aspirin and non-aspirin
 Throat pain medications

Personal Test Kits

Blood Pressure Meters
 Cholesterol tests
 Colorectal cancer screening tests
 Home drug tests
 Ovulation indicators
 Pregnancy tests
 Thermometers

Skin Care

Anti-itch lotion
 Bunion and blister treatments
 Cold sore and fever blister medications
 Corn and callus removal medications
 Diaper rash ointment
 Eczema cream
 Medicated bath products
 ProActive Solution

Stomach Care

Acid reducers
 Antacid gum, liquid or tablets
 Anti-diarrhea medications
 Gas prevent food enzyme dietary supplement
 Gas relief drops for infants and children
 Ipecac syrup
 Laxatives
 Pinworm treatment
 Prilosec
 Upset stomach medications

Not Acceptable*

Aromatherapy	Hair regrowth
Baby bottles and cups	Low "carb" foods
Baby oil	Low calorie foods
Baby wipes	Oral care
Breast enhancement system	Petroleum jelly
Cosmetics	Shampoo and conditioner
Cotton swabs	Skin care
Dental fl oss	Spa salts
Deodorants	Sun tanning products
Facial care	Tooth brushes
Feminine care	Safety Glasses
Fragrances	Veneers

Dual Use- Requires Doctor Letter*

Acne Medications & Treatment
 Foot spa
 Herbs
 Homeopathic treatments
 Massagers
 Minerals
 Multivitamins
 Nasal decongestant inhaler
 Nasal decongestant spray or drops
 Nasal strips to improve congestion
 Saline nose drops
 Sleeping aids
 Special supplements
 Special teeth cleaning system
 Vitamins
 Wart removal medications

** Plan restrictions may apply. Check with your plan administrator. Subject to changes & updates.*

