Claim Reimbursement Form

Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

Mail Claims to: .....PO Box 19040 Kalamazoo, MI 49019

Fax Claims to: ..... (269) 349-3275

E-Mail Claims to: .....FSA@GroupMarketingServices.com

Call .....(269) 343-2611 ext. 113

Employer:_____ Employee Name:_____

Employee Social Security #:_____ E-mail Address:_____

☐ My Address has Changed: _____ Phone:_____

Dependent Care Expense Claims

Name of Care Provider:_____ Provider's Tax Payer ID_____

Care Provider's Address _____

Name of Dependents	Period Covered From	To	Amount Incurred
Total Dependent Care Expense Claim			

*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 $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Medical, dental, optical & prescription drug expenses **must first be submitted and considered for payment under all applicable insurance plans**. Claims cannot be considered for reimbursement from your Unreimbursed Medical Expense Account without an insurance plan explanation of benefits (EOB).

If you had elected to automatically reimburse any GLEA Insurance Plan expenses (i.e. deductible or copay) from your FSA it isn't necessary to complete this form. You will receive an FSA reimbursement check shortly after receiving your GLEA Insurance Plan EOB.

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Was Incurred	Claim Amount	Internal Use Claim Number
TOTAL MEDICAL CARE EXPENSE CLAIM					

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Flexible Spending 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's Signature Date