Section 125 Flexible Spending Account

Employee Enrollment Information

PAYCHEX®

HR Services

What Is an FSA?

Your benefits package includes a Flexible Spending Account (FSA), which allows eligible employees to set aside a specific pretax dollar amount for unreimbursed medical, dental, vision, orthodontia, and dependent care expenses. If you have predictable out-of-pocket expenses, you may want to consider enrolling in the FSA.

Depending on your plan, you have the option to join two separate FSA accounts:

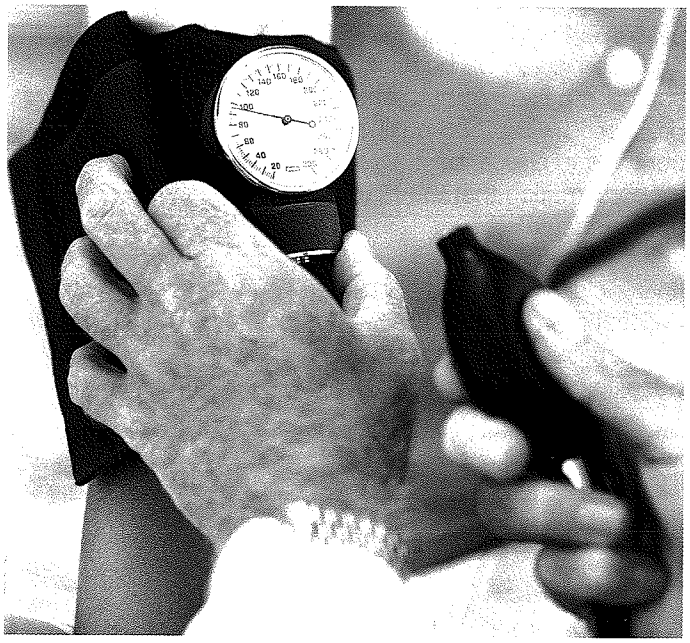
An Unreimbursed Medical Account* can be used for eligible medical, dental, and vision expenses. Examples include:

- Office visit co-pays
- Deductibles
- Prescription eyeglasses or contact lenses
- Dental cleanings
- Orthodontia

*For a list of common medical, dental, and health-related expenses typically considered to be qualifying expenses, please refer to the list on the back of the Flexible Spending Account (FSA) Reimbursement Claim Form for Unreimbursed Medical Expenses in this booklet or go to benefits.paychex.com.

A Dependent Care Account can be used for custodial expenses for a claimed dependent. Examples include:

- Day care center or babysitter to allow you (and your spouse, if married) to work, actively look for work, or be a full-time student
- Custodial or elder care



Why Should I Participate in an FSA?

Tax Savings. FSA deductions come out of your paycheck before most withholding taxes are computed, reducing your taxable income and **increasing your take-home pay!**

Budgeting. Regular payroll deductions help you budget medical, dental, vision, orthodontia, and dependent care expenses.

Ease and Convenience. The Paychex Online Flexible Spending Account site is available 24 hours a day/7 days a week, and you can contact Paychex Employee Services at 877-244-1771 Monday through Friday from 8:00 a.m. to 8:00 p.m ET.

When Can I Enroll in FSA?

Open Enrollment

If you meet the plan's eligibility requirements outlined in the Summary Plan Description (SPD)*, you can enroll or change your annual election for the upcoming year during the open enrollment period using our website or automated phone system. The effective date for benefit plans elected during open enrollment is January 1 of the following year.

Sole proprietors, partners in a partnership, greater than two percent owners of an S-Corporation, and members of LLCs taxed as such, and their family members, are ineligible to participate in a Section 125 plan.

You do not need to re-enroll in the FSA plan each year. If you do not submit a change or a request to cease participation during open enrollment, the annual election amount currently on file will be used for the following plan year.

Note: The IRS maximum annual employee contribution for Unreimbursed Medical Expenses (UME) for 2015 is $2,500. Please refer to the SPD* for your plan's maximum contribution as it may be different from this amount.

*You can view the SPD at benefits.paychex.com or request a copy from your employer.

Entry Date Enrollment

If you are a new employee who has met the eligibility requirements outlined in the SPD, you need to submit a paper enrollment form, which can be obtained from your employer or online. If you are eligible for enrollment, but do not enroll prior to your eligibility/effective deadline, you will not be eligible again until January of the following year unless a qualifying event occurs.

How Do I Know How Much to Contribute?

Use the Flexible Spending Account Deduction Worksheet in the back of this booklet to calculate your eligible expenses and determine the per-pay-period FSA deduction amount. You can also use our online calculator at www.paychex.com/print/fsa-calc.

Important: Be sure to consider the maximum amount your employer allows for unreimbursed medical expenses (refer to the SPD) and any amount he is contributing toward the plan. The maximum household deduction* allowed for dependent care expenses, per federal guidelines, is $5,000.

*A "household" can be described as the total number of taxpayers (living as spouses as defined under federal law) who are filing tax returns either jointly or separately. The amount of dependent care assistance is limited to $5,000 per tax year ($2,500 for married individuals filing separate returns).

Enrolling

You can enroll in the FSA plan using one of the following options:

1. Online
   - Log in to benefits.paychex.com and select **Flexible Spending Account**.
   - If you have not already registered, select **Register for a New Account** and follow the prompts.

2. Phone
   - Dial 877-244-1771 and follow the prompts.

How Do I Get Reimbursed?

Eligible Expenses

Medical expenses are eligible for reimbursement provided that they are to diagnose, treat, or prevent an existing medical condition, and you have not been reimbursed for them through any other benefits plan. Some items may require a prescription, doctor's note, or additional certification from a medical provider to show expenses are eligible.

For a list of common medical, dental, and health-related expenses typically considered to be qualifying expenses, please refer to the list on the back of the Flexible Spending Account (FSA) Reimbursement Claim Form for Unreimbursed Medical Expenses in this booklet or go to benefits.paychex.com.

Submitting Claims

After you have paid for a medical or dependent care expense using out-of-pocket funds, submit a request for reimbursement with documentation to substantiate the eligibility of the purchase.

You can submit claims online and fax or mail written substantiation for each item to Paychex. Third-party receipts must include: the name of the service provider, date(s) of service, dollar amount of the service, and a description of the service provided. A prescription, along with the prescription product name, must be included with the receipt for over-the-counter medicine and drug purchases other than insulin. A prescription number is not considered acceptable documentation.

If you submit a claim through the website, it will not be processed until all supporting documentation is received. The submission will be reviewed and, if it is approved, you will receive reimbursement from your FSA. Claims are processed within two business days of receipt. Please continue to check the status of the claim on the website for confirmation that the claim has been accepted and approved.

If your claim is on hold or denied, you will receive written notification explaining the reason for the hold or denial. You can access your claims status anytime at benefits.paychex.com or by calling 877-244-1771.

Orthodontia

For orthodontia reimbursement, you must provide a copy of an orthodontia contract (or a written statement from the orthodontist, Form FSA045) indicating the length of treatment and schedule of payments. This information is required since treatment of orthodontia is ongoing, and reimbursement of medical expenses prior to services being rendered is not permitted.

You will not be reimbursed in full if the orthodontia bill is paid up front. Once Paychex receives the contract, you must submit a claim form and itemized receipt from the service provider in order to be reimbursed. The claim form and receipt must match the amount listed on the payment schedule of the orthodontia contract.

Note: You can elect to submit only one claim form each plan year for the total amount of orthodontia care as opposed to monthly amounts. Services will be allocated over the length of the contract, and you will receive reimbursement as services are incurred.

Reimbursement Request Timeframes

You have up to 90 days ("closeout period") after the end of the plan year (December 31), or termination of your employment, to submit claims for reimbursement. Eligible expenses must be incurred during the plan year (up to and including your termination date) while you are an active participant.

Your employer may choose to offer one of the following options for your FSA plan.

- Your employer may offer a grace period up to and including March 15 of the following year to incur expenses that can be reimbursed from your prior year's account. This only applies if you were an active participant on the last day of the plan year (December 31) and have a balance remaining in your prior year's account. If a reimbursement received by March 31, 2015, is put "on hold" because we need additional documentation, you have until May 15, 2015, to submit the required documentation.

- Your employer may offer an option to carry over up to $500 of unreimbursed medical expense funds from the current year to the following year. This allows you to incur expenses up to and including December 31 of the following year that can be reimbursed from your prior year's account. This only applies if you were an active participant on the last day of the plan year (December 31) and have a balance remaining in your prior year's account. If a reimbursement received by March 31, 2015, is put "on hold" because we need additional documentation, you have until May 15, 2015, to submit the required documentation.

Reimbursement requests will be processed in the order in which they are received. If your employer offers a grace period or $500 carryover, submit reimbursement requests for services from the previous plan year before you submit claims for the current year to ensure that you receive the maximum benefit.

FSA Debit Card

If available through your plan, you can use an FSA debit card to access your funds and pay for FSA-eligible items and services at a point-of-sale terminal rather than submitting a claim form for reimbursement.

You can also use your FSA debit card at www.paychex.com/fsastore-employee to purchase FSA-eligible products.

Depending on the items purchased, you may still need to submit documentation to validate the expense as eligible under the plan.

Contact your employer to determine if the FSA debit card is offered. To stay up-to-date about vendor card acceptance and see the most current list of accepting merchants, refer to www.sig-is.org.

FSA Direct Deposit

FSA direct deposit allows you to receive medical and dependent care claim reimbursement through direct deposit to your bank account. Contact your employer to determine if this feature is offered.

Termination

If your employment is terminated, you will have 90 days to submit receipts for expenses incurred on or prior to your termination date. Additionally, you have 90 days from your termination date to submit documentation for any claims that were placed on hold or required substantiation prior to your termination date.

Forfeitures

All claims for services incurred on or before December 31 must be submitted by March 31 of the following calendar year. If unclaimed funds remain in your account after the claim filing and resolution deadlines, they are forfeited to the plan and cannot be reimbursed.

If your employer offers the grace period, you will have until March 15, 2015, to incur expenses; however, you must submit requests for reimbursement by March 31. If unclaimed funds remain in your account after this time, they are forfeited to the plan and cannot be reimbursed.

If your employer offers the carryover option, you can carry over up to $500 of your prior year's remaining account balance; however, any amounts in excess of the plan's carryover limit will be forfeited to the plan and cannot be reimbursed.

Please contact your plan administrator to determine whether your company offers the grace period or carryover option.

Changing Your Deduction

Your FSA deduction cannot be changed during the plan year unless you experience a qualifying event. Qualifying events include:

- Marriage* or divorce
- Death of your spouse* or dependent
- Birth or adoption of a child
- Termination or commencement of spouse's* employment
- Change in employment status from part-time to full-time or full-time to part-time for you or your spouse*
- Unpaid leave of absence by you or your spouse*
- Eligibility or ineligibility of Medicare/Medicaid
- Cost-motivated dependent care changes, such as cost increases/decreases (for example, relative becomes available to watch child)

*As defined under federal law.

Please refer to the SPD for more information about changing your deduction. If a qualifying event has occurred, you must submit supporting documentation and enrollment modifications to your employer within 30 days of the event.

In addition, under federal regulations you cannot move money between your medical and dependent care accounts.

What Tools Can I Use to Manage My FSA?

Visit the Paychex Online Flexible Spending Account site at benefits.paychex.com or use the Paychex mobile app at any time to:

- access claim, payment, and balance information
- review account balances and elections
- request an SPD or FSA-related forms

You can also call the automated Paychex Employee Services phone line at 877-244-1771.

PAYCHEX®

Flexible Spending Account Deduction Worksheet

This is not an enrollment form. This worksheet is intended to assist you with the enrollment process by helping you calculate your applicable expenses and how much money would be in an FSA deduction each pay period.

Note: Expenses incurred by or on behalf of a domestic partner and/or a domestic partner's child(ren) are not reimbursable.

Medical/Dental/Vision Reimbursement Account

Annual Medical Expenses, such as:

Deductibles and co-pays	$ _____
Routine physical exams	$ _____
Prescriptions	$ _____
Chiropractic care	$ _____
Other	$ _____

Annual Dental Expenses, such as:

Deductibles and co-pays	$ _____
Routine check-ups	$ _____
Orthodontia	$ _____
Other	$ _____

Annual Vision Care Expenses, such as:

Exams	$ _____
Eyeglasses	$ _____
Contact lenses, solutions, cleaners	$ _____
Other	$ _____

Total Estimated Medical/Dental/Vision Expenses

$ _____ (Annual Amount, cannot exceed company max.) ÷ _____ (# of Pay Periods*) = $ _____ (Per Pay Period)

Dependent Care Reimbursement Account

Annual Dependent Care Expenses:

Payment to a dependent care facility or individual	$ _____
Payment to other care providers	$ _____

Total Estimated Dependent Care Expenses

$ _____ (Annual Amount, cannot exceed $5,000 IRS max.) ÷ _____ (# of Pay Periods*) = $ _____ (Per Pay Period)

Total Per-Pay-Period Reduction

(Add total estimated medical/dental/vision expenses and total estimated dependent care expenses.)

$ _____ Total Per Pay Period

*Weekly, 52 pay periods • Biweekly, 26 pay periods • Semimonthly, 24 pay periods • Monthly, 12 pay periods

Paychex Use Only
Client BIS ID _____

PAYCHEX

Election Form/Compensation Reduction Agreement Flexible Spending Account

SECTION 1 - EMPLOYEE INFORMATION (print)

Office/Client Number _____

Company Name _____ Employee Telephone Number (___) _____ - _____

Employee Name _____ Social Security Number _____

Address _____ City _____ State _____ ZIP Code _____

Email Address _____

SECTION 2 - ENROLLMENT OPTIONS (select one)

☐ **New Enrollment or Annual Enrollment Changes**
Date of Hire _____ / _____ / _____

Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met.

Annual enrollment changes will be effective on the first payroll following January 1.

☐ **Debit Card**
Dependent's name *(if applicable)* _____

Notes: Participants may only request a debit card if their employer has selected the service. If the debit card option is selected and the Plan does not offer the debit card service, no card will be requested. Refer to your Summary Plan Description for plan features.

Participants may choose only **one** dependent.

☐ **Change In Status**
Date of Event _____ / _____ / _____

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

- ☐ 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

* These changes are allowable only if eligibility is affected.

SECTION 3 - ENROLLMENT ELECTION

☐ Annual Medical/Dental/Vision Election $_____ (UME)
Cannot Exceed Company Maximum

☐ Annual Dependent Care Election $ _____ (DCA)
Maximum $5,000.00

DCA is issued for custodial care of a dependent, not for medical expenses of a dependent.

☐ Discontinue my Enrollment in Medical/Dental/Vision Care

☐ Discontinue my Enrollment in Dependent Care

Notes: To discontinue enrollment, a change in status reason must be selected.
To calculate your per-pay-period deduction, divide your annual amount by the number of pay periods remaining in the plan year.
In accordance with IRS regulations, employee contributions cannot exceed the lesser of the company's plan maximum or $2,500.00. Employers may contribute an additional amount which will be added to the Employee's contribution amount to equal the total annual election amount

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year ____ / ____ / ____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. I cannot change or revoke this election at any date prior to the next plan year unless I experience a change in status (also referred to as a qualifying event). If, during my next enrollment period, 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 as set forth in this election form for the next plan year. As a participant, I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

Reduction of Pay

- ❖ I understand that my pay will be reduced each pay period by the amount of my required contribution for the benefit option(s) I have elected until this agreement is amended or terminated. The reduction in my pay under this agreement will be in addition to any reductions under other agreements or benefit plans.
- ❖ I understand that my pay reduction will be automatically adjusted if my required contributions change while this agreement is in effect and that 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.

Reimbursements

- ❖ I understand that my Employer will hold my contributions for payment of eligible expenses incurred within the Plan Year and that reimbursement will be available only for qualifying expenses.
- ❖ I agree to notify my Employer if I believe that any expense for which I have received reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer for any liability Employer may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- ❖ I understand that I will have a closeout period after the end of the plan year during which I can submit eligible expenses incurred during the plan year (and grace period if applicable). I understand that I will forfeit any remaining balances, including those in excess of any allowable carryover amount; I have at the end of the closeout period for which I have no eligible expenses to submit.

FSA with an HSA

- ❖ If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.

Employee Signature _____ Date _____ / _____ / _____

ENROLL or REVISE ENROLLMENT at https://benefits.paychex.com or on the FSA Information Line by dialing 877-244-1771.
MAIL or FAX to Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: 585-389-7349

FAX: 585-389-7003

Submit or view claims **ONLINE: https://benefits.paychex.com**

Paychex Employee Services: 877-244-1771, automated system available 24/7, Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

FOR OFFICE USE ONLY
Docket # _____

PAYCHEX®

Flexible Spending Account (FSA) Reimbursement Claim
Unreimbursed Medical Expenses

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (___) _____ - _____

Email Address _____

Visit **https://benefits.paychex.com** at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ Enclose copies of all itemized bills and/or receipts from your provider or a copy of your orthodontia services contract, if applicable. Use blue or black ink only to identify FSA items on receipts. **Do not use highlighter. Copies of personal checks, cancelled checks, or credit card receipts are not valid for verification of service.**
- ☐ Verify that bills and receipts contain:
  - date of service
  - description of service
  - cost of service
  - provider's name
  - provider's address
  - prescription name (if expense is for a prescription)
- ☐ If you are currently funding a Health Savings Account (HSA) in addition to your FSA, your FSA is a limited purpose FSA and may only be used to pay for vision, dental, and preventative medical expenses.
- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Claim	Name of Service Recipient	Relationship to Employee	Service Date(s)	Service Description	Service Provider	Amount
SAMPLE	John Doe	☐ Self ☐ Spouse ☑ Dependent	07/07/07	☑ Medical ☐ Dental ☐ Vision ☐ Pharmacy	Dr. Jones	$521.43
01		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
02		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
03		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
04		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
					TOTAL	$

If you have more claims, please complete additional Reimbursement Claim forms.

CLAIM INFORMATION

I certify that the information here is true and correct; that the expenses incurred were for myself, my spouse as defined by federal law, or my eligible dependents; and that these expenses are not reimbursable under any other health plan coverage.

Employee Signature _____ **Date** _____ /_____ / _____

Paychex FSA Reimbursement Expenses-at-a-Glance

Some items below may require a prescription, doctor's note or additional certification from a medical provider to show expenses are reimbursable under a health FSA to the extent that they are to diagnose, treat, or prevent an existing medical condition. Expenses incurred by or on behalf of a domestic partner and/or a domestic partner's child(ren) are not reimbursable.

HEALTH CARE EXPENSE EXAMPLES THAT ARE ELIGIBLE:

A.E.D. for home use
Alcoholism treatment
Ambulance services
Astigmatic keratotomy
Bandages
Blood pressure monitors
Braille books and magazines (to extent prices exceed the prices of regular books and magazines)
Car equipped for disabled person (to extent price exceeds the price of regular car)
Clinic charges
Contact lenses/solution
Co-pays and deductibles
Crutches
Dental retainer
Dentist's fees (not cosmetic)
Denture adhesives
Dentures/dental implants/partials
Doctor's fees (not cosmetic procedures)
Eye exam/prescribed eyeglasses
Eyeglass repairs for Rx glasses
Diabetic supplies and test strips
Diagnostic/screening services
Drug addiction treatment facilities
Fertility treatments
Guide dog/care
Hearing aids/batteries/repairs
Hospital services
Hot/cold packs and heating pads
Insulin
Laboratory fees
Lasik eye surgery/radial keratotomy
Lead-based paint removal to treat lead poisoning
Lodging for medical care
Medical monitoring/testing devices
Medical records fees
Midwife expense (medical care)
Nurses' expenses and board
Nursing care
Obstetrical services
Orthodontia (contract required)
Osteopath, licensed
Ovulation monitor
Oxygen equipment
Physical exam
Podiatrist
Prescription medication
Prescription sunglasses
Prosthesis (artificial limbs)
Rental of medical equipment
Rewetting eye drops
Shipping costs (medical care items)
Smoking cessation prescriptions
Special education for physically or mentally disabled family member
Sperm storage fees (temporary)
Sterilization
Surgery/treatments
Telephone (for the deaf)
Thermometer
Transplants
Transportation for essential care
Vasectomies (and reversals)
Wheelchairs
X-ray fees

OVER-THE-COUNTER MEDICINE/DRUG EXAMPLES THAT ARE ELIGIBLE WITH A DOCTOR'S PRESCRIPTION*:

***Over-the-counter (OTC) medicines and drugs** (other than insulin) are no longer eligible for reimbursement under a medical flexible spending account **unless** prescribed by a medical practitioner.

Acne medications
Allergy medications
Allergy nose sprays
Antacids
Antifungal medications
Anti-gas treatments
Antihistamines
Anti-itch treatments
Antiseptic first aid sprays
Calcium supplements
Cold medications
Contraceptives
Cough medications/drops/syrups
Decongestants
Digestive aids
First aid kits/supplies
Gingivitis mouthwash/treatments
Hemorrhoid creams/suppositories
Herbal supplements
Lactose intolerance pills
Laxatives
Medicated rubs/muscle creams
Menstrual cycle medications
Motion sickness medications
Pain relievers/analgesics
Spermicides
Toothache/teething pain relievers
Vitamins/minerals
Wart removal treatments
Weight loss/dietary supplements
Yeast infection creams

HEALTH CARE EXPENSE EXAMPLES THAT ARE NOT ELIGIBLE:

Clip-on eyeglasses
Cosmetic procedures/products
Dental bleaching
Dental floss
Deodorants
Diaper service
Funeral expenses
Illegal treatments or drugs
Insurance premiums
Marital therapy
Medications imported from outside U.S.
Mouthwash
Remedial reading classes
Shampoo
Skin moisturizers/lotions
Soaps
Teeth whitening products
Toiletries
Toothbrushes
Toothpaste
Vitamins used for general health
Warranties for eyeglasses

DEFINITION:
An eligible dependent for Dependent Care Assistance is:

- Any dependent who has not attained 13 years of age and is your dependent under federal income tax rules. (If your child turns 13 during the year, you can stop your contribution at that time.)
- Your mentally or physically impaired spouse or a dependent incapable of caring for himself or herself (for example, an invalid parent).

The dependent must spend at least eight hours per day in your home and have the same principal place of residence as you, the taxpayer, for more than one half of the taxable year. Expenses incurred for, or on behalf of, a domestic partner's child(ren) are not reimbursable.

DEPENDENT CARE EXPENSES THAT ARE ELIGIBLE:**

- Services provided inside or outside your home, but not by your minor child or dependent
- Services provided by a qualified day care facility that cares for six or more individuals at the same time and complies with federal, state, and local laws
- Services incurred to enable you, or you and your spouse, to be employed, in search of employment, or full-time students
- Services for the custodial care of the dependent, not for education or meals
- Child care centers
- Family day care providers
- Babysitters
- Nursery schools
- Caregivers for a disabled dependent or spouse who lives with you
- Household services, provided that a portion of these expenses are for a qualifying dependent and are incurred to ensure maintenance of the dependent's well-being

**Amount that can be reimbursed is not greater than $5,000, your earned income, or your spouse's earned income, whichever is lower.

DEPENDENT CARE EXPENSES THAT ARE NOT ELIGIBLE:

- Dependent care provided to one of your dependents by a family member under the age of 19 who will be claimed as your dependent for tax purposes
- Expenses for food and clothing
- Education expenses, kindergarten and beyond
- Health care expenses for your dependents
- Overnight camps
- Transportation

A more extensive listing of eligible expenses is available at https://benefits.paychex.com.

Paychex Employee Services: 877-244-1771, automated system available 24/7, representatives available Mon. – Fri. 8:00 a.m. – 8:00 p.m. ET

The Internal Revenue Service considers these expenses deductible and eligible for reimbursement through your FSA plan if they are to diagnose, treat, or prevent an existing condition and if you have not been reimbursed for them through any other benefit plan.

FAX: 585-389-7003

Submit or view claims **ONLINE: https://benefits.paychex.com**

Paychex Employee Services: 877-244-1771, automated system available 24/7, Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

FOR OFFICE USE ONLY

Docket # _____

PAYCHEX®

Flexible Spending Account (FSA) Reimbursement Claim
Dependent Care Allowance

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (___) _____ - _____

E-mail Address _____

Visit **https://benefits.paychex.com** at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ **Complete the table below and** enclose copies of all itemized bills and/or receipts from your provider. Use blue or black ink only to identify FSA items on receipts. **Do not use highlighter. We will not accept copies of personal checks, cancelled checks, or credit card receipts as verification of service.**
- ☐ Verify that bills and receipts contain:
  - start and end dates of service
  - provider's name
  - service recipient's age (if dependent under age 13)
  - cost of service
  - service recipient's name
- ☐ **For your convenience, in lieu of an itemized receipt, you may have your Dependent Care Provider sign the Certification From Provider section below.** Otherwise, an itemized receipt for your dependent care expenses will be required.
- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Claim	Name of Service Recipient	Age of Service Recipient	Date of Service Start Date	Date of Service End Date	Service Provider	Amount
SAMPLE	Baby Doe	1 year	10/1/2011	10/31/2011	Ms. Smith	$325.00
01						$
02						$
03						$
04						$
05						$
					TOTAL	$

Note: Dependent Care Claims will be reimbursed up to the year-to-date contributions made to your account at the time of submission. If you submit for dates of service in the future or for amounts above your current contribution balance, reimbursement will automatically be issued once the date has passed and/or additional contributions have been made for this plan year.

If you have more claims, please complete additional Reimbursement Claim forms.

CERTIFICATION FROM PROVIDER

We certify that we are providing Dependent Care Services for the service recipients and service dates listed above for the amounts indicated.

Dependent Care Service is care of, or related household services for, a dependent under age 13 or a dependent or spouse that is incapable of self care, and is not for school tuition. Before/after school care is a qualified expense and should be itemized to break out from cost of school tuition if applicable. Expenses incurred by or on behalf of a domestic partner's child are not reimbursable.

Name of Dependent Care Provider _____

Signature of Dependent Care Provider _____ **Date** _____/_____/_____

CLAIM INFORMATION

I incurred the expenses listed above for reimbursement on behalf of my eligible dependent or spouse for reimbursable items under Section 125 of the Internal Revenue Code.

Employee Signature _____ **Date** _____/_____/_____

FAX: 585-389-7003

Paychex Employee Services: 877-244-1771, automated system available 24/7, representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

Submit or view claims **ONLINE: https://benefits.paychex.com**

MAIL: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000

PAYCHEX®

Flexible Spending Account (FSA) Reimbursement Claim Orthodontia Services

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (_____) _____ - _____

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

HOW WOULD YOU LIKE TO BE REIMBURSED?

Select one:

☐ **DEBIT CARD** – I will be using my **FSA Debit Card** and do **not** want to be reimbursed monthly by check or direct deposit.

Note: By selecting this option, Paychex will place your contract on file. Your card can then be used for the initial fee(s) and to make each monthly payment for the amount indicated in the contract agreement.

OR

☐ **CLAIM PAYMENTS** – I want to receive monthly reimbursements for my orthodontia automatically for the duration of the services based on the terms of my orthodontia contract.

Notes:

- If the terms of your contract change, promptly submit an updated contract or statement from the provider outlining the change.
- Per IRS guidelines, medical services are reimbursed under an FSA as services are incurred. Paychex will process your orthodontia claim on a monthly basis for the duration of the contract. If you choose to pay the full contract up-front to the provider, this will **not** allow your FSA plan to reimburse you the full amount upon submission. The initial fee and records fee may be reimbursed when services begin. Payment date will determine which plan year funds are reimbursed from.

CLAIM AUTHORIZATION

If you are not attaching a contract from the provider, please ensure that the **Certification from Orthodontia Provider** is completed in full and signed by the provider.

If you want Paychex to process your claim by individual monthly payment, submit the **Unreimbursed Medical Expenses** claim form along with a copy of your orthodontia services contract.

I certify that the information herein is true and correct; that the expenses incurred were for myself, spouse, or dependents; that these expenses are not reimbursable under any other health plan coverage; and that these expenses are eligible under Section 125 of the Internal Revenue Code.

Employee Signature _____ **Date** _____ / _____ / _____

CERTIFICATION FROM ORTHODONTIA PROVIDER (to be completed by provider)

Name of Orthodontia Provider _____

We certify that we are providing orthodontia services for _____ .
Patient's Name

Note: Your contract must be completed in full and mathematically correct for your claim to be paid out.

Contract Information

Start Date _____

_____ **Total Dollar Amount of Contract**

\- _____ **Initial Fee** (Date Paid _____) If requesting payment with this claim, indicate here. ☐

\- _____ **Records Fee (if applicable)** (Date Paid _____) If requesting payment with this claim, indicate here. ☐

\- _____ **Insurance (if applicable)**

\- _____ **Discount (if applicable)**

= _____ **Remaining Balance ÷** _____ = _____
total months of service **qualified monthly reimbursable amount**

Signature of Orthodontia Provider _____ **Date** _____/_____ / _____

For Office Use Only

Docket # _____

PAYCHEX®

Flexible Spending Account
Direct Deposit
Enrollment Form for FSA Claims

Use this form to enroll in the Direct Deposit service for your Flexible Spending Account (FSA). With Direct Deposit, your FSA reimbursements will be deposited electronically into your bank account rather than sent to you as paper checks. Use this form if you are enrolling for the first time in Direct Deposit or if you are changing the account that will receive your reimbursements. All direct deposits will be processed within three business days.

Instructions:

- ☐ Complete the Required Information section.
- ☐ Complete the Direct Deposit Information section.
- ☐ **Sign and date the bottom of the form.**
- ☐ Make a copy of this form and retain for your records.
- ☐ Return this form and supporting documentation to:

Fax 585-389-7983

Mail Paychex, Inc.
Attn: FSA Claims
1175 John Street
West Henrietta, NY 14586

Required Information

PLEASE PRINT

Name _____

Social Security No. (last 4 digits) _____

Address _____

_____

E-mail Address _____

Employer Name _____

❑ New Account ❑ Change Account

Direct Deposit Information

I authorize my employer to deposit my FSA reimbursements to the following bank account (select one):

❑ Checking Account Number _____

❑ Savings Account Number _____

❑ Paycard Account Number _____

Attach one of the following (select one) and indicate the name of the bank.

❑ Voided check (deposit slips are not accepted)

❑ Bank letter or specification sheet
(See your local bank representative.)

Bank Name _____

Attach a voided check here.

IMPORTANT: A voided check, bank letter, or specification sheet must be attached.

Authorization

_____ Date ____/____/____
SIGNATURE

Paychex Use Only

Entered by _____

Approved by _____

Date ____/____/____

Client BIS ID _____

For questions about completing this form, call Paychex Employee Services at 877-244-1771.