SINCLAIR SERVICES COMPANY
FLEXIBLE SPENDING ACCOUNT
REQUEST FOR REIMBURSEMENT
(See Reverse Side For Instructions)

EMPLOYEE INFORMATION (Please Print)

Name _____ Employee No. _____
Street Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____
E-Mail Address: _____

HEALTH CARE EXPENSES (Attach Supporting Documentation - See Reverse Side)

Date Exp. Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount to be Reimbursed

*TOTAL HEALTH CARE EXPENSE

*Reimbursement request must total $25.00 or more in order for claim to be processed, except at year-end.

DEPENDENT CARE EXPENSES (Attach Supporting Documentation - See Reverse Side)

Name of Dependent	Age	Dates of Service From	To	Name, Address and Social Security Number, or Tax ID of Provider of Service	Amount of Reimbursement

TOTAL DEPENDENT CARE EXPENSE $

EMPLOYEE SIGNATURE REQUIRED - READ CAREFULLY

The undersigned participant in the Flexible Spending Account (FSA) 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 FSA with respect to such expenses. The undersigned fully understands that he/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 FSA, the undersigned may be liable for payment of all related taxes including federal, state income tax, or FICA on amounts paid from the FSA which relate to such expense. The undersigned also acknowledges that the reimbursements hereby requested have not been and are not reimbursable under any other coverage. I have read and understand the important information on the reverse side of this form.

_____ _____
Employee's Signature Date

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS
Total amount of Request for Reimbursement must be a minimum of $25.00, unless at year-end.

WHEN TO FILE

- Claims are processed as they are received.
- Claims for services incurred for the previous year's contributions are due by March 31st of the following year. They will not be accepted after this date.

HOW TO FILE A CLAIM

- Complete the Request For Reimbursement on the front side.
- Be sure to sign and date the request.
- Attach documentation of your expenses.
- Keep a copy of your claim for your records.
- Incomplete Reimbursement requests will be returned to you and will delay reimbursement on your paycheck.
- Submit the claim to: Sinclair Health Services, P.O. Box 30827, Salt Lake City, Utah 84130-0827.
- To check on the status of a claim call Sinclair Health Services at: 1-888-800-2230.

REQUIRED DOCUMENTATION FOR HEALTH CARE EXPENSES

- For services covered by your medical/dental insurance, submit an Explanation of Benefits (EOB) from your insurance company.
- For orthodontia, if paying in monthly installments, submit a copy of your payment plan with your initial reimbursement request, and if covered by insurance a copy of your EOB. Each month thereafter you only need to submit a reimbursement request for the monthly payment.
- For services **NOT** covered by any medical/dental/vision insurance submit an itemized bill that includes the following information: Provider's name & address, description of services, name of patient, date of service, and amount charged for service. A monthly statement showing balance due is not acceptable.
- For prescriptions requiring a co-payment, submit a copy of the prescription receipt.
- For mileage to/from the doctor, you will need to write an itemized statement indicating mileage and amount of reimbursement you are requesting (currently .24 cents per mile).

REQUIRED DOCUMENTATION FOR DEPENDENT CARE EXPENSES

- Attach a bill or statement from the caregiver indicating the date the services were rendered and the amount charged. BE SURE TO INCLUDE THE AGE (S) OF THE DEPENDENT (S) WITH EACH REQUEST OF PAYMENT.
- The provider Tax ID Number or Social Security Number of the provider.

DEPENDENT CARE EXPENSES - In general, the following rules apply to dependent care expenses:

- The expenses must be incurred while you are working, and be for the care of a dependent who is under age 13 and for whom you are entitled to a dependent deduction under Internal Revenue Service Code Section 151(e), or a dependent who is physically or mentally incapable of caring for himself or herself.
- Reimbursed expenses cannot be claimed as deductions on your personal income tax return.
- 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 capable of taking care of him 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 who is under age 19.
- The total amount reimbursed cannot exceed the actual amount paid into the account.
- You must file a Form 2441 with your tax return.