



FLEXIBLE BENEFIT PLAN ∞ REIMBURSEMENT REQUEST FORM

Igoe Administrative Services recommends utilizing the upload feature available via your on-line account at www.goigoe.com when submitting your reimbursement request. This method provides protection for your personal information in addition to confirmation of receipt. You may also email your request and all supporting documentation to flex@goigoe.com. Please refer to the instructions listed on page 2 of this form if electronic capabilities are not available to you.

INSTRUCTIONS: INCLUDE RECEIPTS AND DOCUMENTATION WITH THIS REQUEST FORM

1. **Complete** all applicable sections of this form. **Remember to sign and date the bottom of this form.**
2. **Attach** all Itemized Bills, Explanations of Benefits, Statements of Service or receipts for your expenses incurred. All supporting documents become a part of this claim and **will not** be returned to you.
3. **Remember to keep original receipts for your records as you may be required to provide documentation directly to the IRS in the event of a personal audit.** Reimbursement requests received incomplete or sent without proper documentation will not be processed.
4. **Requests must be received** no later than 5:00 p.m. PST four (4) business days prior to your company's scheduled reimbursement processing day in order to allow adequate time for auditing.
5. **See the reverse side of this form for additional instructions and for a timeline on requesting reimbursement.**

SECTION A: ABOUT YOU (Please print clearly) **** ALL INFORMATION IN THIS SECTION IS REQUIRED**

Employer Name				
Participant Name		Number of pages	First 5 digits of the Participant SSN	
Home Address	<input type="checkbox"/> Please check if this is a change in address	City	State	Zip
E-mail Address			Phone Number	

SECTION B: MEDICAL CARE EXPENSES INCURRED (for participant and all tax dependents)

SERVICE DATE (mm/dd/yy)	NAME OF DOCTOR / PROVIDER OF SERVICES	DESCRIPTION OF EXPENSE	PERSON INCURRING EXPENSE NAME, AGE, RELATIONSHIP	NET AMOUNT
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
Total Medical Care				\$

SECTION C: DEPENDENT CARE/DAY CARE EXPENSES INCURRED

DATES COVERED	DEPENDENT INFORMATION NAME, AGE, RELATIONSHIP	DESCRIPTION OF EXPENSE	NAME OF PROVIDER	PROVIDER'S TAX ID OR SSN	NET AMOUNT
-					\$
-					\$
-					\$
-					\$
Total Dependent Care					\$

SECTION D: AUTHORIZATION: *REQUIRED (PLEASE SIGN AND DATE)

As a participant in the Plan, I certify that all above expenses were incurred during the Plan Year while I was covered under the Flexible Benefit Plan and that the expenses have not been or are not being reimbursed under any other benefit plan. I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to this request. Each expense for which payment or reimbursement is requested must be a proper expense under the Plan. If not, I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that **NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE.** I authorize the account in my name to be reduced by the amount requested.

PARTICIPANT'S SIGNATURE: _____ **DATE:** _____

Additional Instructions for Submitting Reimbursement Requests

Medical Care Reimbursement Requests:

Submit Reimbursement Requests for eligible medical, dental and vision care expenses that will not be reimbursed by any other employer-sponsored benefit plan and which would qualify as a deduction on your income tax form.

Dependent Care Reimbursement Requests:

Submit Reimbursement Requests for eligible day care/child care expenses that will not be reimbursed by any other employer-sponsored benefit plan and which would qualify as a credit on your income tax form.

Expenses must be incurred within your eligible timeframe of your company's sponsored FSA Plan Year

Timeline for Submitting Your Reimbursement Request

In order to guarantee that your request is processed, your request for reimbursement **MUST** be received **four (4) business days** prior to your company's scheduled processing date. Requests that are received after this time may remain pending until the next scheduled processing date. Please refer to your **Flexible Benefit Plan Highlights** for your company's processing cycle. Please see the timeline below for an estimate of the time required for auditing and entry of your request into the Igoe systems. Please note that **holiday closure WILL** change the timeline indicated below by **increasing** the amount of time required for your request to be audited and entered into our system to await your company's scheduled processing date. Requests submitted over the weekend are considered received on Monday or the next business day in the event of a holiday.

Request is submitted prior to 5:00 PST on one of the following business days :	Monday	Tuesday	Wednesday	Thursday	Friday
Request is ready for processing and viewable online for verification:	Friday	Monday	Tuesday	Wednesday	Thursday

Please Remember the Following When Submitting Your Reimbursement Request

- Complete **ALL** applicable sections on reverse side.
- Submit with this form proof of your expenses: an itemized bill from your medical care provider, an explanation of benefits from your insurer, or a statement of service from your dependent care/child care provider or similar receipt.
- Proof of expense **must** show: date of service, description of service or expense, name of doctor or provider of service, prescription name and amount of expense.
- Submit your reimbursement request and proof of expenses using one of the following methods:
 - Log on to your secure Flex Account at www.goigoe.com, select the "Upload Forms" option and attach your scanned Request for Reimbursement and all substantiating information. Please note that this is the only option that protects your personal information.
 - Attach your Request and all substantiating information to an email and send it to flex@goigoe.com
 - Fax your Request and all substantiating information to 858-777-5424; 888-357-6307
 - Mail your Request and all substantiating information to: Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
- Reimbursement requests can be made at any time within your company's plan year. Please verify this information by referring to your **Flexible Benefit Plan Highlights** or by contacting your company's Benefits Department.
- Reimbursements are not assignable and can only be payable to you, the participant – not a relative, spouse or provider.
- If you have any questions about or would like to check the status of your reimbursement request, visit the Igoe Administrative Services website at: www.goigoe.com. You may also email your question to: flex@goigoe.com.