WORKTERRA
a CAREERBUILDER® company

CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES

1. Instructions (incomplete claim forms will not be processed)

– Please see the full list of instructions on the following page.

2. Employer / Employee Information ❍ **New Address? Check the box if the address listed below is new**

Employer Name ____________________

Employee Name ____________________ **SSN** ____________________

Street Address ____________________

City / State / Zip Code ____________________ **Daytime Phone** ____________________

3. List of Eligible Expenses
*****For receipts/EOBs to substantiate Visa Card Transaction(s), please mark "yes" in the Visa Card field.***

Family Member	Relationship to Employee	Date of Service	Description of Expenses	Visa Card (Yes/No)	Amount Requested
JANE	SPOUSE	1.1.18	PRESCRIPTION	NO	$15.00
> Enter the total amount requested for reimbursement and attach receipts before sending					

4. Employee Authorization
I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my FSA plan and that these expenses have been incurred during the plan year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program and that I am solely responsible for the accuracy of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my FSA plan.

Employee Signature ____________________ **Date** ____________________

5. Employee Release if Emailing Claims
According to the regulations as set forth by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have established the appropriate administrative, technical, and physical safeguards to prevent Protected Health Information (PHI) from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. The safeguards WORKTERRA has put in place include sending your supporting receipts, EOBs and claim forms through our secure fax or through US mail.

If you choose to send us your documentation containing PHI through email (custserv@WORKTERRA.com), you understand that such email is not secured and you are responsible for securing your information in an appropriate manner. Any transmission of your PHI through email may result in unauthorized disclosure of your PHI and, consequently, an exposure risk to you or your dependents. By sending us your claims via email and by signing the below, you understand that WORKTERRA is not responsible for any information transmitted by you or your agent on your behalf.

Employee Signature ____________________ **Date** ____________________

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CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES ~ *INSTRUCTIONS*

Completed claim forms should be faxed or mailed to the following address:
WORKTERRA, P.O. Box 11657, Pleasanton, CA 94588 Fax: 925.460.3929
You can also email your claim to claims@WORKTERRAbenefits.com

- Complete the Employee / Employer Information requested under Section 2.
- Fully complete all fields in Section 3. **Claim forms with incomplete information will be rejected.** Please list each receipt and itemize each expense. Additional pages may be attached. Receipts with a description of service(s) rendered or an Explanation of Benefits from your insurance provider are required for reimbursement. Credit card receipts or cashed checks are not acceptable documentation.
- Under Section 4, read the Employee Authorization carefully and sign noting your agreement.
- If emailing your claim, under Section 5, read the Employee Release carefully and sign noting your agreement.
- **Keep complete copies of all receipts and forms submitted to WORKTERRA for audit purposes.** WORKTERRA is not responsible for providing copies to participants.
- Be sure to include your employer's name on the form along with the last four of your social.
- Be sure to note if there has been an address change. There is a circle to check on the claim form to indicate that the address listed is new.
- Attach all receipts to the claim form before sending to WORKTERRA. Receipts MUST include the following information:
  - Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
  - The date the service was provided or the date the item was purchased;
  - The name of the service provider or the merchant;
  - Description of the service or item purchased;
  - A prescription or letter of medical necessity from your health provider if it is an OTC drug or medicine purchase; and
  - The amount/cost of the item or service provided.
- All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item. Effective January 1, 2011, all OTC drug and medicine expenses must be accompanied by a prescription or letter of medical necessity from your provider to be eligible under your FSA plan.
- Be sure all expenses were incurred during the plan year or period of active plan participation before submitting your claim.
- Verify that your expenses were not previously submitted or paid through your Visa card.
- If your claim is rejected, you will be notified in writing explaining the reason and requesting the necessary information needed to process your claim.

Top two reasons claims are denied

- Cancelled checks and credit card receipts are provided as proof of an incurred expense / purchase and
- The statement from the provider lists only payments made (does not list a description of the services rendered or does not list the dates of the services / purchases).

Per the IRS, receipts are required that show both a description of services / purchases and the date of the services / purchases.

DIRECT DEPOSIT FORM AUTHORIZATION AGREEMENT

Mail completed forms to WORKTERRA, PO Box 11657, Pleasanton, CA 94588 or fax to: 925.460.3929

This form can be used to initiate, change or cancel your direct deposit. This service alleviates the time spent waiting for a check in the mail and is available to all plan participants. Please note – this form must be sent to WORKTERRA two weeks before the reimbursement method is changed.

All requests for Direct Deposit must be submitted on this form and include a voided check for the account. Forms without a voided check attached will not be processed. Deposit slips are not acceptable as appropriate routing numbers may not be available.

Reimbursement will only occur if you have submitted a claim to WORKTERRA with receipts for eligible expenses. WORKTERRA does not guarantee payments into your account on any date. WORKTERRA is not responsible for bank charges of any type that you may incur for direct deposit transactions. Do NOT assume that a payment has been made to your account at any time. You are solely responsible for checking with your bank as to the deposit amount and date of direct deposits made to your account. You may use the on-line account balance system (through WORKTERRA' WORKTERRA), WORKTERRA' automated account balance system by phone or contact WORKTERRA Customer Service to check the status of your flexible spending account.

By submitting this form, you understand that your claims reimbursements will be deposited into the listed account.

Please place an x in the appropriate box:

❍ Initiate Direct Deposit ❍ Change Account ❍ Cancel Direct Deposit

Employer Name:

Employee Name: SSN:

Employee Address: Daytime Phone:

Bank Name & Address:

Bank Routing #: Bank Account #:

❍ Checking Account ❍ Savings Account

Authorizing Signature:

For assistance in finding routing and account numbers please see below:

SAMPLE CHECK:
Andrew Sample 1234
Martha Sample
123 Main Street
Anywhere, NY 10000 ______________,19___

Pay to the
Order of____ $ ____________

____ Dollars

Anywhere Bank
Anywhere NY 10000

ROUTING ACCOUNT

For ______________________________ ______________________________

120015005 1010120001 1234

Routing Number must be nine digits. If the first two digits are not 01 through 12 or 21 through 32, your direct deposit request will be rejected. **The Account Number** can be up to 17 characters (both numbers and letters) - include hyphens but omit spaces and special symbols.

DEPENDENT CARE BILL FROM PROVIDER FORM

Mail completed forms to WORKTERRA, *PO Box 11657, Pleasanton, CA 94588 or fax to: 925.460.3929*

This form is for those participating in the Dependent Care Account. This form can be used in lieu of multiple receipts from your dependent care provider. For example, you can fill out the form for any amount of time up to the end of the plan year, have your provider sign the form (agreeing to the information you have completed), complete and attach to a claim form and fax or mail it to WORKTERRA. If you use this form, you will not need to send in weekly, monthly or quarterly receipts. Should you change care providers during the year, request another form from WORKTERRA and ask to replace the one on file. This claim will stay on file and as contributions are received by WORKTERRA, payments will be forwarded automatically (either by direct deposit or by a mailed paper check).

This form must be completed in its entirety, signed by your provider and attached to a completed claim form in order to be processed by WORKTERRA. If you need Customer Service assistance, representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail WORKTERRA Customer Service at custserv@WORKTERRA.com. Please do not email your claim or include any confidential information, such as your Social Security number, in your email for security reasons.

Employer Name ______________________________

Employee ______________________________ **SSN** ______________________________

Street Address ______________________________

City / State / Zip Code ______________________________ **Daytime Phone** ______________________________

Name of the person for whom the services are provided: ______________________________

____

Cost of Services Provided – amount paid per week / per month / per year – for all dependents listed above:

$ ________ per week $ ________ per month $ ________ per year

Dates of Service:

From _______ / _______ / _______ To _______ / _______ / _______
(Example – from 1/1/18 to 12/31/18)

Name of the Person or Organization Providing the Service:

Print Name of Provider ______________________________ **Tax ID or SSN or Provider** ______________________________

Signature of Provider ______________________________ **Date Form Completed** ______________________________

This form only needs to be completed once during the period of service dates provided. If there is any change to the above information a new form must be submitted in its place. A new form must be submitted for any other period not included in the dates of service portion noted above. As a participant in this plan, you are responsible for providing accurate information including the verification of eligible expenses as well as the amounts requested. **Keep complete copies of all receipts and forms submitted to WORKTERRA for audit purposes.** WORKTERRA is not responsible for providing copies to participants.

FLEXIBLE SPENDING ACCOUNTS ~ MOST FREQUENTLY ASKED QUESTIONS

How do I get reimbursed from this plan?

– You need to send in a claim form (instructions are on page three) and receipts for eligible expenses.

How do I know if my expenses are eligible for reimbursement?

– A partial list of eligible expenses is included in this packet.

What information needs to be included on receipts for reimbursement?

– Attach all receipts to the claim form before sending to WORKTERRA. Receipts MUST include the following information:

- Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
- The date the service was provided or the date the item was purchased;
- The name of the service provider or the merchant;
- Description of the service or item purchased;
- A prescription or letter of medical necessity from your health provider if it is an OTC drug or medicine purchase; and
- The amount/cost of the item or service provided.

– All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item. Effective January 1, 2011, all OTC drug and medicine expenses must be accompanied by a prescription or letter of medical necessity from your provider to be eligible under your FSA plan.

Why is a description of service required on my receipts?

– The IRS determines eligible expenses and the documentation required to claim a reimbursement from this plan. A documented description of services or products is required to prove that your incurred expense is eligible for reimbursement under the guidelines set by the IRS for this plan.

Why would WORKTERRA deny my claim?

– The most commons reasons claims are denied are:

- Missing or illegible information;
- Submission of ineligible expenses;
- Receipts are lacking a description of service / items purchased;
- Expenses have been incurred outside the plan year; and
- Expenses have already been submitted (duplicate claims) or paid by your Visa card.

How long does it take WORKTERRA to process claims?

– All claims are processed within three to five business days after receipt of complete information. Reimbursements could be timed differently depending on your employer. If you have questions on the timing of your claim, please call our Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770.

May I fax my claim to WORKTERRA?

– Yes – claims should be faxed to 925.460.3929.

If I fax a claim, do you need originals in the mail?

– No, please keep the original receipts for your records.

What is the deadline for submitting claims?

– Please contact Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770 for submission deadlines for your specific plan.

Why would the reimbursement I received be less than the claim I sent?

– You may have exceeded the amount available to you. Medical FSA reimbursements are limited to your annual election (the amount you elected to set aside at the beginning of the plan year). Reimbursements are paid up to the annual election amount at any time during the plan year but cannot exceed this amount. Dependent Care

reimbursements are limited to the amount in your account at the time of your claim.

For example, if you have made three contributions of $50 each, you would have an account balance of $150. If you sent in a claim for $200, you will receive only the $150 until further contributions are made. As soon as we receive further contributions to the plan, the balance of the claim (in this case $50) will be paid up to the amount in the account, not to exceed your annual election amount for that plan.

– A portion of your claim may have been denied. If so, you will receive a letter in the mail explaining why that portion of your claim was denied. If you have questions on the rejection of your claim, please call our Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770.

What if I need to change my annual elections?

– You may only change your annual elections during the plan year if you qualify for a "change in family status". To qualify, you must experience a life-changing event such as marriage, divorce, birth or adoption of a child, death of a spouse or dependent, or change in spouse's employment, etc. These changes are defined by the IRS and outlined in your plan communication materials. If you have a question about your status, you should consult your employer.

Are my spouse and I both able to elect $5,000 as our Dependent Care annual election?

– If you are married and file a joint tax return, the maximum amount you may elect is $5,000. The maximum amount available if you are married but filing separate returns is $2,500. If you file separately, you cannot claim the same expense in each of your dependent care accounts.

What happens if I don't claim all the money in my account?

– According to the IRS guidelines, funds that are not claimed during the plan year are forfeited to the plan. This is called the "use it or lose it" clause. Funds are not transferable from one plan year to another and they are not available for other benefits. The unused funds are retained by your plan sponsor and are often used to offset administrative costs of the plan.

What information does WORKTERRA report to the IRS?

– WORKTERRA does not supply information to the IRS related to your FSA. Your plan sponsor may be required to file an IRS form 5500 which includes participation and total disbursement information (does not include individual FSA account information) and your participation in the Dependent Care Assistance program will be reported on your W2 at the end of the year by your employer.

Tips for a successful claim submission

– Verify all expenses were incurred during the plan year before submitting;
– Verify the expenses were not previously submitted;
– Make sure that all of the information provided on the claim form is clearly legible – claim forms that cannot be read will not be processed;
– Make sure each receipt and each expense / purchase is itemized; and
– Make sure all expenses / purchases have a description on the receipt or Explanation of Benefits.

How can I find out what my account balance is or when WORKTERRA sent me a claim reimbursement?

– You are able to logon through the Member Center at www.WORKTERRA.com for online account balance information and information on claims paid.

– WORKTERRA representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail WORKTERRA Customer Service at custserv@WORKTERRA.com. Please do not include any confidential information, such as your Social Security number, in your email for security reasons.

ELIGIBLE MEDICAL EXPENSES – post 12/31/2010

The IRS has established a list of medical, dental and vision care expenses that are eligible for reimbursement under this plan. You may request reimbursement for eligible expenses for yourself, your spouse or your dependents. If you incur an expense that is not listed here and you would like to know whether or not it is an eligible expense under this plan, please contact WORKTERRA Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770. You may also refer to IRS Publication 502 "Medical and Dental Expenses." You can order this publication by calling the IRS at 800-829-3676.

Eligible Medical Care Expenses (partial list)

Acupuncture
Ambulance
Artificial Limbs
Chiropractors' fees
Coinsurance
Contraceptive prescriptions
Co-payments
Crutches
Diabetic supplies
Gynecologists' fees
Health insurance deductibles
Hearing aids / batteries
Hypnosis for medical reasons
Immunizations / vaccinations
Insulin
Mileage / travel costs related to an eligible expense
Laboratory fees
Orthodontia
Orthopedic shoes
Physical therapy fees
Prescription drugs
Psychiatrists' / Psychologists' fees
Psychotherapists' fees
Routine physicals
Seeing-eye dog
Skilled nurses' fees
Speech therapists' fees
Smoking cessation treatments & prescriptions
Sterilization fees
Treatment for substance addiction
Wheelchairs
Weight loss treatments (prescribed by a physician)

Eligible Dental Care Expenses (partial list)

Dentists' fees (other than for cosmetic services)
Dentures
Orthodontia
Periodontist fees

Eligible Vision Care Expenses (partial list)

Eye exams
Laser / Lasik eye surgery
Prescription eyeglasses and / or contact lenses
Radial keratotomy / ortho keratology

Ineligible Expenses

This partial list includes medical, dental or vision expenses that are considered not eligible for reimbursement from your Medical Care Reimbursement Account:

- Cosmetic surgery or procedures of any kind
- Health club memberships
- Insurance premiums
- Lens replacement insurance
- Marriage counseling
- Over-the-counter drug and medicine expenses without a prescription or letter of medical necessity (includes items such as acid controllers, allergy & sinus medicines, antibiotic products, anti-gas, anti-itch & insect bites, baby rash ointments/creams, cold sore remedies, cough, cold & flu medicines, laxatives, pain relief & sleep aids)
- Physical therapy for general well-being
- Supplements prescribed by an alternative provider (i.e. acupuncturist)
- Union dues

ELIGIBLE DEPENDENT CARE EXPENSES

A Dependent Care Reimbursement Account allows you to set aside part of your salary each pay period on a pre-tax basis to reimburse eligible expenses incurred for the care of your child, disabled spouse, elderly parent or other dependent who is physically or mentally incapable of self-care, so that you (and your spouse, if applicable) can work.

Eligible Dependents

- Your child age 12 or younger of whom you have custody and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with custody (rights to claim the child for tax purposes) can consider the child an eligible dependent under this plan.
- Your child of any age who is physically or mentally unable to care for him/herself, even if he/she does not entitle you to a deduction on your federal tax return.
- Your spouse who is physically or mentally unable to care for him/herself, even if he/she does not entitle you to a deduction on your federal tax return.

Guidelines for Eligible Dependent Care Expenses

- Only care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under age 19 would be eligible.
- If your dependent is in first grade or higher (through age 12), the cost of schooling must be separated from the cost of care submitted for reimbursement.
- If your dependent is in a grade before first grade and the cost of care and the cost of schooling can be separated, then only the cost of care is reimbursable. However, if the cost of schooling cannot be separated from the cost of care, the total cost is reimbursable.
- A dependent care center or child care center would be eligible for reimbursement (if the center cares for more than six children, it must comply with all applicable state and local regulations).
- A housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent would be eligible for reimbursement.
- To qualify for reimbursement, you must provide your dependent care provider's tax ID number or social security number on your federal tax return (IRS form 2441). If you fail to provide this information, your reimbursements may not be eligible and may be reclassified as taxable income by the IRS.
- You are responsible for making sure that the expenses you submit for reimbursement are considered eligible expenses by the IRS. If you are not sure whether an expense is eligible, please contact WORKTERRA Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770. You may also refer to IRS Publication 503: Child and Dependent Care Expenses which is available by calling the IRS at 800-829-3676 or through the IRS WORKTERRA site in the Forms and Publications section.
- If you are married and file a joint tax return, the maximum amount you may elect is $5,000. The maximum amount available if you are married but filing separate returns is $2,500. If you file separately, you cannot claim the same expense in each of your dependent care accounts.