Information About
Reimbursement Accounts (Flexible Spending Accounts)

The administrator for the Dartmouth College Reimbursement Account Plan is Crosby Benefit Systems, Inc. As part of their service, Crosby processes reimbursement checks on a weekly basis and also offers the option of direct deposit.

The mailing address for claims is:

Crosby Benefit Systems, Inc.
P.O. Box 929125
Needham, MA 02492-9125

It is important to note that claims *must* be received by 5 p.m. on Wednesday to be processed for the following week. And please bear in mind that mail from the Upper Valley typically takes three days to reach the Boston area, where Crosby is located. To save time, you may want to consider faxing your claim to the Crosby Service Center at (617) 928-0001.

You should also double-check Crosby's requirements for documentation before sending in your claim. Further details can be found on the Medical Care or Dependent Care reimbursement request forms, or on Crosby's Web site <*www.crosbybenefits.com*>. The site contains forms, contact information, and a list of Frequently Asked Questions. The Crosby Service Center toll-free phone number is 1-800-462-2235, Monday through Thursday from 8 a.m. to 7 p.m. and Friday from 8 a.m. to 5 p.m.

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Flexible Benefits Plan
MEDICAL CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS, INC.**

Employee Information

CHECK BOX IF NEW ADDRESS

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Please also notify employer of any address changes.

Employee Name ______________________________ Soc.Sec.No.______-_____-______
Last First MI

Employer ______________________________ Email address ______________________________

Home Address ______________________________
Street City State Zip

Home Phone No. (______)_______________ Work Phone No. (______)_______________
area code area code ext.

Spouse and Dependent Information

If expenses for reimbursement are for your spouse or dependent children, please complete this section.

NOTE: Your spouse is the person to whom you are married at the end of the year. Your dependents are those individuals defined as your dependents by the IRS for income tax reporting purposes.

Dependent's Name	Date of Birth	Relationship to Employee

Expenses

Please list all out-of-pocket health care expenses submitted to, but not covered by, other medical benefit plans, as well as other expenses eligible for payment from your Medical Care Reimbursement Account.

Description of Expense	Date of Service	Amount*

*Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, Workers' Compensation, or any other policy of health insurance.

TOTAL EXPENSES $___________

Submit receipts or statements with this form, showing the service or product provided, to whom, by whom, the date and the out-of-pocket expense. Retain a copy for your records. **Canceled** checks are NOT acceptable. **Neglecting to submit required documentation may delay claims processing**.

Employee Certification

I hereby certify that all items submitted for reimbursement comply with the Section 125 Reimbursement Plan and such items have not and will not be covered by any other plan of any employer or any other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and/or state income tax return for any year. My employer does not accept responsibility for direct payment to any individuals other than the employee. I have read and understand the information on the reverse side (or page 2) of this form.

Please SIGN

Employee Signature ______________________________ **Date** _______________

IMPORTANT INFORMATION

Medical Care Eligible Expenses

In general, but with notable exceptions, a participant may be reimbursed for a medical care expense which is deductible for federal income tax purposes, but which has not and will not be reimbursed by any other sources, and which has not been and will not be deducted on the employee's income tax return.

The IRS offers Publication 502 which summarizes those medical expenses that are allowable deductions for tax purposes. Although much of Publication 502 can be used as a guideline for a Medical Care Reimbursement Account, **Publication 502 states as allowable some expenses which ARE NOT reimbursable under a Medical Care Reimbursement Account.** For example, insurance premiums and expenses for long term care services are not reimbursable under a Medical Care Reimbursement Account. Publication 502 is available on the IRS website at www.irs.gov.

Some examples of eligible expenses include co-payments and deductible payments required by health insurance; also vision, hearing, dental, over-the-counter medications, and most prescription drug expenses not covered by health insurance. Examples of ineligible expenses include insurance premiums; vitamins/supplements for general good health; cosmetic procedures, products and prescriptions; and counseling not related to a medical condition.

Supporting Documentation

For All Expenses: Attach bills or evidence of charges that clearly state all of the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

Medical and dental expenses covered partially by your health care plan(s) are generally allowable. The health care plan's Explanation of Benefits statement that contains the above information may be submitted as supporting documentation. Submit pharmacy receipts for prescription drug claims. Cash register receipts will be considered insufficient documentation.

Cosmetic Procedures and Drugs for Cosmetic Purposes:

Cosmetic procedures (for example, teeth bleaching) and drugs (prescription and nonprescription) to be used for a cosmetic purpose are not reimbursable. Under the plan, medical care "does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease." For this reason, these expenses are generally not reimbursable. Due to this provision, the drug name is required for all medication expense submissions.

Doctors Notes:

For some expenses, a doctors note is required to verify that the expense qualifies as medical care. To be allowable, a doctors note must be written by a doctor of medicine, osteopathy, dentistry, podiatry or optometry, or an authorized chiropractor. Furthermore, a doctors note must contain all of the following items: 1. Date (a note must be provided each year); 2. Patient's name; 3. Doctor's name, address and signature; 4. the medical condition; 5. the prescribed treatment; 6. that the treatment is medically necessary; and 7. the duration of treatment required.

Transportation Primarily for Medical Care:

Expenses for transportation primarily for, and essential to, medical care are reimbursable. For such expenses, information must be provided that states the nature of medical care (for example, "doctor's appointment") and the date service was provided.

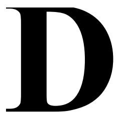
Submission of Reimbursement Requests

Please mail reimbursement requests to: Crosby Benefit Systems, PO Box 929125, Needham, MA 02492-9125 or fax to: 617-928-0001. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable. To expedite adjudication, please include a completed Reimbursement Request Form with each submission.

Please Note

Service dates for reimbursable expenses must fall within the plan year. Participants who leave the plan during the plan year will only be reimbursed for expenses incurred while they were participating in the plan. Expenses incurred before participation began or after participation has terminated will not be reimbursed.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Expenses are to be submitted to Crosby Benefit Systems, using the Medical Care Reimbursement Request Form. Please contact your Human Resources Department or Crosby Benefit Systems for more information.



Flexible Benefits Plan
DEPENDENT CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS, INC.**

Employee Information

CHECK BOX IF NEW ADDRESS

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Please also notify employer of any address changes.

Employee Name ______________________________ Soc.Sec.No.______-_____-______
Last First MI

Employer ______________________________ Email address ______________________________

Home Address ____
Street City State Zip

Home Phone No. (______)_________________ Work Phone No. (______)_______________________
area code area code ext.

Dependent Information

Please complete this section for all dependents for whom expenses listed on this form were incurred. Your dependents are those individuals defined as your dependents by the IRS for income tax reporting purposes.

Dependent's Name	Date of Birth	Relationship to Employee

Expenses

Please list all out-of-pocket dependent care expenses for which you are requesting reimbursement.

Description of Expense	Date of Service	Amount

TOTAL EXPENSES $___________

Submit receipts or statements with this form, showing the service or product provided, to whom, by whom, the date and the out-of-pocket expense. Retain a copy for your records. **Canceled** checks are NOT acceptable. **Neglecting to submit required documentation may delay claims processing**.

Provider Information

Provider Name ______________________________ Tax ID/SS No. ______-_____________

Address ____
Street City State Zip

Employee Certification

I hereby certify that my request to be reimbursed for dependent care expenses complies with the Section 125 Reimbursement Plan and the Internal Revenue Code requirements for claiming dependent care deductions. I further certify that such expenses will not be deducted or taken as tax credits on my personal federal and/or state income tax return for any year.

In addition, if I am requesting payment for household services performed in my home which include care for qualified dependents, I hereby certify that I have met the IRS requirements of filing all appropriate tax forms and have paid Social Security tax on my household employee's wages. I agree to furnish a copy of filed tax forms and canceled checks verifying Social Security payment if requested by the Plan Administrator. I have read and understand the information on the reverse side (or page 2) of this form.

Please SIGN

Employee Signature ______________________________ **Date** _________________

IMPORTANT INFORMATION

Dependent Care Eligible Expenses

- The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse, or $5,000, whichever is less. If married and filing separate tax returns, you cannot exceed $2,500 individually. Also, participants may need to choose between a dependent care reimbursement account or the dependent care tax credit because the tax credit maximum is reduced dollar for dollar for each dollar placed into a reimbursement account. Be aware that the plan year may not coincide with the tax year.

- The expenses must be employment-related expenses incurred for the care of a dependent of the employee who is under age 13 and for whom the taxpayer is entitled to a dependent deduction under Internal Revenue Code section 151(c), or a dependent of the employee who is physically or mentally incapable of caring for himself or herself.

- The payments cannot be made to a person who is claimed as a dependent by the employee.

- Dependent care expenses submitted before the service is provided are not reimbursable. If a claim is submitted in advance of the actual service date, it will be denied and returned to the participant, with a request that the expense be resubmitted after the date of service. For example, expenses for a particular month should not be submitted until the last day of that month.

- Expenses for DAY camp programs are allowable; however, if camp hours exceed the employee's working hours, submit ONLY that portion of expenses incurred for work-related hours. OVERNIGHT CAMP is NOT an allowable expense**,** even on a prorated basis.

- If services are provided by a dependent care center, which provides care for more than six individuals (other than a resident of the facility), the center must comply with all state and local laws.

Supporting Documentation

For All Expenses: Attach bills or evidence of charges that clearly state all of the following:

1. Name of person receiving the service
2. Name and address of service provider
3. Nature of service
4. Amount of reimbursable expense under the plan
5. Date(s) of service
6. Provider's Tax ID or Social Security Number

Also, please complete the Provider Information for dependent care expenses on the front of this form.

Submission of Reimbursement Requests

Please mail reimbursement requests to: Crosby Benefit Systems, PO Box 929125, Needham, MA 02492-9125 or fax to: 617-928-0001. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable. To expedite adjudication, please include a completed Reimbursement Request Form with each submission.

Please Note

Service dates for reimbursable expenses must fall within the plan year. Expenses must be incurred on or after the participant's effective date and before the end of the plan year.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Expenses are to be submitted to Crosby Benefit Systems, using the Dependent Care Reimbursement Request Form. Please contact your Human Resources Department or Crosby Benefit Systems for more information.

CROSBY
BENEFIT SYSTEMS

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Newton, MA 02461
800-462-2235 / 617-928-0700
617-928-0001 FAX

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Transit Benefits

CROSBY *is a leading employee benefits company that designs, delivers, and services cutting-edge benefits programs*