Integrity Administrators, Inc.

INTEGRITY ADMINISTRATORS, INC.

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

REIMBURSEMENT REQUEST FORM

Employer: _____

Employee Name & Address

Last Name: _____ **First Name:** _____ **M. I.** ____ ☐ **Male** ☐ **Female** **Phone #:** (____) ____-____ **Employee # or SSN #:** ____/____/____

Street: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Instructions: *Complete the information below for Medical Care Expenses incurred by you, your Spouse, or your other eligible Dependents. For information as to what Expenses can and cannot be reimbursed, and for the special rules that apply to claims for expenses incurred during any Applicable Grace Period, see the Salary Reduction Plan Summary Description. You must provide insurance Explanation of Benefits (EOB's), hospital or doctor bills, pharmacy receipts, or other evidence from independent third parties that the Expenses were incurred (canceled checks or balance due bills are not acceptable). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you.*

	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5	Expense #6
Date medical service or item actually provided:						
Name of person receiving medical service:						
His/her relationship to employee:	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Type of service (Medical, Dental, Rx, Etc):						
Proof of expense is attached (including name or type of medicine or drug):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Total Expense:	$	$	$	$	$	$
Amount paid or reimbursed by another plan:	$	$	$	$	$	$
Reimbursement Requested:	$	$	$	$	$	$
					Total Reimbursement Requested:	**$**

I authorize the above expenses to be reimbursed from my Health FSA Account. To the best of my knowledge, my statements on this Form are true and complete. I certify all of the following:

- The expenses qualify as valid Medical Care Expenses under Code §213(d), as defined in the Salary Reduction Plan document ("the Plan") Health Flexible Spending Account (FSA) Coverage Option. These expenses are not for cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries.
- These expenses have not previously been reimbursed under the Health FSA or any other plan, and I will not seek reimbursement for them under the Medical Insurance Plan or any other health plan.

In addition, I understand that expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a medical practitioner's statement that an expense is to treat a specific medical condition, or a more detailed certification from me). I understand that if my claim is for expenses incurred during any applicable Grace Period: (1) the expenses will be reimbursed first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year; and (2) claims are paid in the order in which they are approved.

X: _____ _____

Employee Signature Date

Please Make Sure to Sign and Date This Form, Then Send It or Fax It Along With Your Supporting Documentation To:

Integrity Administrators, Inc.
P.O. Box 13128 Sacramento, CA 95813
(916) 921-3388 (800) 562-9383 Fax: (916) 921-3383