



LOUISIANA STATE UNIVERSITY
Reimbursement Request
Health Care and Dependent Care
Spending Accounts

This request is for reimbursement of (check only one):

- Health Care Flexible Spending Account Expenses
(Complete Sections A, B, and D.)
- Dependent Care Flexible Spending Account Expenses
(Complete Sections A, B, C, and D.)

Name: Last, first, MI _____

Daytime Phone _____

Social Security Number _____

A. LIST OF EXPENSES	Claims must be incurred during the current plan year. Bills must be paid before they can be reimbursed. The bill or statement must indicate the date of service and the amount paid. If it does not show "paid," please attach a copy of your explanation of benefits, a cancelled check, or any other receipt of payment. Minimum claim amount is \$25; however, final claim for the plan year may be less than \$25.		
Date of Service	Payment Made To	Service Provided	Amount
Total Expenses			\$
B. SPOUSE AND DEPENDENT INFORMATION		(If expenses were for your spouse or for a dependent) Your spouse is the person to whom you are married at the end of the year. Your dependent is your child, stepchild, parent, other close relative, or a person who lives in your home, if you provide over half of his/her support.	
Person's Name	Date of Birth	Relationship	
C. DEPENDENT CARE - OTHER INFORMATION			
1. Do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, go to #5)	5. Dependent Care Provider Information		
2. Spouse's expected earned income this year: <input type="checkbox"/> If less than \$5000, specify amount \$ _____ <input type="checkbox"/> \$5000 or more	Name _____ Address _____		
3. Type of income tax return filed: <input type="checkbox"/> Separate <input type="checkbox"/> Joint	TIN (Taxpayer ID No.) _____ <input type="checkbox"/> Provider would not supply TIN		
4. Are your Spending Account reimbursements expected to exceed \$2500? <input type="checkbox"/> Yes <input type="checkbox"/> No	OR Social Security No. _____ <input type="checkbox"/> Provider would not supply SSN		
D. AUTHORIZATION			
I direct and authorize LSU Foundation to release funds from my Health Care Spending Account equal to the total expenses listed in Section A above. I certify that the expenses listed above qualify for reimbursement under the Tax Saver Flexible Benefits Plan and have been incurred and paid by me. These expenses claimed for reimbursement have not been reimbursed by my health care plan or any other health care plan such as my spouse's. Bills, statements, or other evidence of these expenses are attached. In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursements in excess of \$5000 from all employer-sponsored dependent care spending account plans and that the service provider is not a child of mine under the age of 19 and is not otherwise a person who can be claimed by my spouse or by me as a dependent for federal income tax purposes. I understand that I am responsible for using my account(s) properly and for complying with all IRS regulations.			
Signature _____			Date _____ / _____ / _____
FOR HUMAN RESOURCE USE ONLY	Claim # _____	Date Entered: _____	

DESCRIPTION OF ELIGIBLE EXPENSES

A. Health Care Expenses

Health care expenses are expenses incurred by you, your spouse, or your dependents, which have not been and will not be reimbursed by any medical or dental plans. Health care includes the prevention, diagnosis, treatment and care of a physical or mental defect, illness, injury or disease and transportation necessary for health care.

Examples of **covered** health care expenses are listed below.

1. Amounts that are not paid by the medical and dental plans, such as deductibles, coinsurance and amounts in excess of plan limits.
2. The cost of eye examinations, frames, lenses, contact lenses, hearing examinations and hearing aids.
3. The cost of prescription medicine and drugs, including birth control pills and insulin, and over-the-counter drugs.
4. The cost of transportation primarily for and essential to medical care. Amounts paid for meals and lodging while receiving medical care away from home, up to \$50 per person per day.
5. The cost of attending a special school for mentally or physically handicapped persons.

Examples of expenses that are **NOT** covered are listed below.

1. Expenditures that are merely beneficial to the general health of the person such as exercise, fitness, nutrition, recreation, vacation or membership in a spa or health club, unless prescribed by a physician for a specific condition.
2. The cost of medical or dental insurance premiums.
3. Expenses which have been or will be taken as a deduction for federal income tax purposes.
4. Amounts which have been paid for by insurance.

B. Dependent Care Expenses

Dependent care expenses are expenses incurred by you to enable you to work. If you are married, unless your spouse is a full-time student or is incapable of self-care, your spouse must also work. The expenses must be for the care of your children age 12 or younger or for the care of other individuals who live in your house and rely on you for at least half of their support or are physically or mentally incapable of self-care.

Examples of **covered** dependent care expenses are listed below.

1. Amounts paid to a baby sitter, or nurse, or licensed day care center.
2. Amounts paid for services performed outside your home for the care of dependents or your spouse. If the care is for a disabled dependent who is age 13 or older, that dependent must spend at least 8 hours each day in your home.
3. The full amount paid to a nursery school, including school-provided meals and education services.
4. The full amount paid to a housekeeper, maid or cook, when regular duties include dependent care provided to a qualifying individual.
5. Amounts paid to a relative who provides dependent care services, if the relative is not your or your spouses' dependent, and is not your child or stepchild who is under age 19 at the end of the year.

Examples of expenses **NOT** covered are listed below.

1. The cost of food or clothing.
2. The cost of transportation between your house and the place where dependent care services are provided.
3. The cost of overnight camping or nursing home facilities.
4. Expenses for which a dependent care tax credit is taken.
5. Medical expenses for dependents.
6. Taxes paid on items purchased.

For a complete description of the Health Care and Dependent Care Accounts, please refer to the Tax Saver Flexible Benefits Plan booklet.

Please return this form to:

Benefits Service Center
Office of Human Resource Management
Louisiana State University
304 Thomas Boyd Hall
Baton Rouge, LA 70803

Phone (225) 578-8200

NOTES

Your contribution to the dependent care spending account is limited to:

- Up to \$5000 per year, or
- Up to \$2500 per year if you are married, and you and your spouse file separate tax returns, and
- The lesser of your earned income and that of your spouse; further,
- If your spouse does not work because he or she is a full-time student or is disabled, your spouse's income is considered to be \$200 a month if you have one eligible dependent, \$400 a month if you have two or more eligible dependents.

In addition, you are required to report, on your federal income tax return, the name, address, and tax identification or social security number of the providers of dependent care, your costs for which have been reimbursed through the spending account. The tax I.D. number is not required when the provider of dependent care services is a tax-exempt organization, such as a church-sponsored nursery school or a county day care center.