CompuSys/Erisa Group Inc
STATE OF NEW MEXICO CLAIM FORM
FLEXIBLE SPENDING ACCOUNT

PLEASE PRINT OR TYPE. SEE REVERSE SIDE FOR INSTRUCTIONS AND IMPORTANT INFORMATION

Administrative Office: CompuSys/Erisa Group Inc. • 13706 Research Bld. Ste.308 • Austin, TX 78750 • (800) 933-7472 • Fax (512) 597-4692 • E-mail, nmflex@cserisa.com

EMPLOYEE INFORMATION

NAME		SOCIAL SECURITY NUMBER	
MAIL ADDRESS: if your address has recently changed, you must update your address through your employer	CITY	STATE	ZIP CODE
EMAIL ADDRESS:	HOME: AREA CODE AND PHONE NUMBER	WORK: AREA CODE AND PHONE NUMBER	

HEALTH CARE REIMBURSEMENT

To ensure prompt processing, attach copies of the Explanation of Benefits statement from your insurance carrier and any additional supporting documentation as described on the reverse of this form for each of the reimbursement requests listed below.

	DATE OF SERVICE	SERVICE PROVIDER	AMOUNT OF REIMBURSEMENT
1			
2			
3			
4			
5			
6			
7			

REIMBURSE FROM PLAN YEAR_____(specify year) **TOTAL AMOUNT TO REIMBURSE: $**

DEPENDENT CARE REIMBURSEMENT

Please provide all of the requested information

	DEPENDENT'S NAME & RELATIONSHIP TO YOU	DOB	DATES OF SERVICE	AMOUNT PAID
1				
2				
3				
4				

TOTAL AMOUNT TO REIMBURSE: $

DEPENDENT CARE PROVIDER INFORMATION (If your Dependent Care Provider does not provide you with an itemized receipt the PROVIDER must fill in the information below as a receipt of services)

For instructions, see "Dependent Care Expenses" in the Supporting Documentation section on the back of this form.

NAME OF DEPENDENT CARE PROVIDER		SOCIAL SECURITY/TAX-ID NUMBER
DATE OF SERVICE: FROM / / TO / /	AMOUNT PAID	NATURE OF SERVICE: (i.e. day care, other school care, etc)
SIGNATURE OF DEPENDENT CARE PROVIDER		DATE

EMPLOYEE CERTIFICATION AND SIGNATURE

I certify the charges attached or listed above are eligible under the Internal Revenue Code, the charges have been incurred, and that I have not been reimbursed by, nor are the charges reimbursable by any other source. I also certify that I will not claim these charges as a credit on my personal income tax return. I also certify that the total dependent care expenses (if any) for which I am requesting reimbursement for this plan year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that the expenses I am submitting for payment are eligible expenses, as explained in my open enrollment material and in I.R.S. publications 502 and 503.

EMPLOYEE'S SIGNATURE	DATE

White: Administrative Office Canary: Employee Copy

IMPORTANT INFORMATION ON REIMBURSEMENTS

Healthcare - Eligible Expenses: In general, you may be reimbursed for a Healthcare expense which qualifies as a deduction on federal income tax returns. Also, the expense must not be reimbursed by any other source (including insurance, or a spouse's flexible spending account) and must not be deducted on your income tax return. Some examples of eligible expenses include coinsurance, deductibles, vision, hearing, non-cosmetic dental care, and certain prescription drug expenses not covered by your health insurance, or your spouse's health insurance. For more information about eligible expenses, you may refer to the State of New Mexico's flexible spending website at nmflex.com and I.R.S. publications #502 and #503.

Dependent Care - Eligible Expenses: In general, the following rules apply to dependent care expenses:

- The annual amount submitted for reimbursement must be less than the lower of your income or your spouse's income.
- The expenses must be for the care of your dependent who is under age 13 and entitled to a dependent deduction under Internal Revenue Code § 151(e) or a dependent who is physically or mentally incapable of caring for himself or herself.
- The care must be necessary in order for you and your spouse to work.
- The payments cannot be made to a person who is claimed as your dependent.
- If the services are provided by a dependent care center which provides care for more than six individuals, the center must comply with all state and local laws.
- The services must not be educational in nature as detailed in Internal Revenue Code § 151(e).

Supporting Documentation: The following supporting documentation must be submitted with this form:

- All expenses: For all expenses, submit bills that clearly state:

  -Name of person receiving the service
  -Name of service or supplies
  -Date service was rendered
  -Name and address of provider
  -Amount charged-please note that an "estimate" is not sufficient
  -Amount covered by insurance, if applicable

  Expenses covered by your Healthcare plans: Medical, vision and dental expenses covered by your Healthcare plans must be submitted under those plans first. Attach a copy of the "Explanation of Benefits" statement to claim amounts not paid by your Healthcare plans. ("Explanation of Benefits" is the document sent to you from your insurance provider showing the full expense, the amount your insurance paid, and the amount that you are responsible for.)

- Dependent Care Expenses: Complete the "Dependent Care Reimbursement" section on the front of this form and attach a signed receipt from your dependent care provider. If you do not have a signed receipt, have your dependent care provider supply the additional information requested in the "Dependent Care Provider Information" section of this form and sign in the space provided to verify that charges have been incurred. Submit all bills or receipts with your completed claim form.

Send completed form to: CompuSys/Erisa Group Inc
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Austin, TX 78750-1840
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Email: nmflex@cserisa.com