first CONCORD
Benefits Group

www.firstconcord.com
P.O. Box 67220
Lincoln, NE 68506

Phone: 402-423-4454
Fax: 402-423-4549

Section 125 Claim for Reimbursement

Dear Employee:

You will find below the First Concord Benefits Group policy on reimbursement for expenses from the Flexible Spending accounts.

In order to be reimbursed from the Flexible Spending Accounts, the expenses must not be eligible for payment from any other third party (i.e. health or dental insurance). The information listed below must be provided:

- A First Concord Benefits Group claim form signed by the employee
- An insurance company Explanation of Benefits form or a bill (or copy of a bill) that contains the following information:
  - Provider's name
  - Date of service
  - Person for whom the service was performed
  - A brief description of the services performed
  - Amount charged

Most insurance company Explanation of Benefits forms contain this information. Bills you receive from your provider and prescription receipts also contain this information.

We **cannot** accept statements where the only information provided is a "balance due" or "received on account". These statements lack several key pieces of information.

Also, please note that there will be a $25.00 minimum check amount before a claim payment is made.

Thank you for your cooperation.

FIND MORE INFO AT THESE SITES:

www.firstconcord.com/fsa
get program information and find a list of eligible expenses

www.firstconcordlh1ondemand.com
view account balances, statements and create claims

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Section 125 Claim for Reimbursement

Employer:	Claim Year:
Employee Name:	Social Security Number:

Dependent Care Expenses (DOCUMENTATION REQUIRED)

Name, Address of Provider of Services	Dates Expense Incurred	Amount
		$ 0.00
		$ 0.00
	TOTAL	$ 0.00

NOTE: The Day Care expense is an eligible expense only if it enables you and your spouse to be able to work. No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or if your child or step-child is under the age of 19.

Unreimbursed Healthcare Expenses (DOCUMENTATION REQUIRED)

Name, Address of Provider of Services	Dates Expense Incurred	Amount
		$ 0.00
		$ 0.00
		$ 0.00
		$ 0.00
		$ 0.00
		$ 0.00
	TOTAL	$ 0.00

Personally (employee) Owned Insurance Expense (DOCUMENTATION REQUIRED)

Name of Company and Type of Insurance	Date Premium Expense Incurred	Amount
		$ 0.00

Read Carefully: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, and city income tax on amounts paid from the Plan which related to such expense.

Employee Signature

Date

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