North Coast Administrators, Inc. Reimbursement Claim Form

Name of your Employer: ______________________________ Your First and Last Name ____

Address ____City_________________________State______________Zip_________

Social Security # ______________________Day Time Phone Number (___) ____________Email Address______________________________

You have 3 Claim Filing Options:

- ⇒ File claim online - Log in to your account at www.myflexonline account submit your claim electronically once you click "continue" after entering your claim, you will be able to upload from this screen.
- ⇒ Claim details may be entered on this Claim Form and electronically sent, mailed or faxed to: 440-835-1188
- ⇒ The MyFlexMobile App can easily be downloaded to your iPhone or android phone for free!

Health Care Expense Claims for Reimbursement under an FSA or Employer Paid HRA

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount Paid
		*TOTAL HEALTH CARE EXPENSE CLAIM		$

Check which benefit applies to this claim filing:

_____ FSA Claim Reimbursement

_____ HRA Claim Reimbursement

FSA Dependent Care Expense Claims for Reimbursement

Name of Dependent(s)	Period Covered From To	Name, Address and Taxpayer ID Number of Care Provider	Amount Incurred
		*TOTAL DEPENDENT CARE EXPENSE CLAIM	$

Please indicate age of child (ren)__________

NOTE: Your daycare provider will need to sign and date this form if you do not have supporting documentation, such as an itemized receipt. I hereby certify that I provided adult or child daycare services to the above individuals in accordance with the amounts and dates requested.

PROVIDER'S SIGNATURE ____ **DATE** ____

The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of him or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19. **Children are eligible through the age of 12**.

READ CAREFULLY:

The undersigned Plan participant 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 employer reimbursement account plan with respect to such expenses and that the health care expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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, or city income tax on amounts paid from the Plan which relate to such expenses.

____ ____

Employee Signature Date

INSTRUCTIONS FOR ON LINE AND PAPER CLAIM FILING

To view your account on line visit http://www.ezflexplan.com/northcoast and then Employee Login Tab. This will link you to the www.myflexonline.com site where you will need to establish an account if you have not already done so.

1). *New!!* To request **reimbursement on line** from the Employee website, visit the "Request Payment" tab and select the Claim Type, etc. Follow the prompts, when you view and print continue you may upload your claim and your receipts, EOB's etc. and view your completed claim submission. You're done!

Or-

1). Complete this claim form and sign where indicated.

2). **Attach receipts with dates of service and amounts, day care billing summary, or insurance company statements, (*whichever applies to your situation*).** Cancelled checks and balance due bills are not acceptable.

3). Claims are processed in accordance with your company schedule.

4). **If** your company allows **DIRECT DEPOS**IT of funds, you may print a form on the home page of the http://www.ezflexplan.com/northcoast website to request Direct Deposit/ACH of funds. Please complete and file along with your claim.

5). The **MyFlexMobile App** can easily be downloaded to your iPhone or android phone for free!

MAIL OR FAX THIS FORM TO:

NORTH COAST ADMINISTRATORS, INC.

875 Westpoint Parkway Suite # 510

Westlake, OH. 44145

(440) 835-4900 • 1 (800) 677-6690
Claim Fax (440) 835-1188

General Guidelines:

To qualify for reimbursement, expenses must be incurred during the Plan Year for which you are requesting reimbursement.

1. **Flexible Spending Account – Health Care Reimbursement (FSA):** may used for medical expenses incurred by you or your family that are not covered by another health plan. Eligible items include but are not limited to:
   - Medical co-payments, co-insurance and deductibles, out of pocket Dental and Vision Expense Items
   - Certain out-of-pocket, dental, hearing and vision services, excluding cosmetic procedures
   - Most prescription drugs, contraceptives and insulin and ongoing medications including co-pays and co-insurance.
   - Purchase and rental of most medical devices
2. **The Dependent Care Reimbursement Account (FSA):** may be used for expenses incurred for child care while you work.
   - Your child must be age 12 or under and reside with you or are disabled
   - Your child or other dependent over the age of 12 must be incapable of self-support and must be dependent upon you for IRS purposes.
   - The individual caring for your child age 12 and under or other dependent must not be your tax dependent
   - Reimbursement cannot exceed $5,000 per year for single individuals or married couples filing joint tax returns ($2,500 if married filing separately) or the earned income of you or your spouse, whichever is less.
3. **HRA- Health Reimbursement Account (HRA):** A health reimbursement account or HRA is funded by the employer. Therefore unless otherwise stipulated, payment may only be made for health care that is allowable by your health care provider after their claim review has already been made. In most instances, the HRA plans DO NOT cover dental or vision expenses unless they are associated with a medical condition that is also allowable under your traditional insurance plan and has been credited to your deductible amount.

TERMINATED EMPLOYEES:

TERMINATED EMPLOYEES GENERALLY ONLY HAVE 60-90 DAYS FROM DATE OF TERMINATION OR COVERAGE END DATE DEPENPENDENT UPON INSURANCE CARRIER CONTRACTS AND THE EMPLOYER PLAN DOCUMENT TO SUBMIT FINAL RECEIPTS FOR PAYMENT. THEREFORE, PLEASE INSURE THAT YOU ARE AWARE OF YOUR BENEFIT AVAILABILITY UPON TERMINATION. RECEIPTS MUST BE DATED PRIOR TO TERMINATION DATE AND WHILE YOU WERE AN ACTIVE PLAN PARTICIPANT. DEBIT CARDS ARE TURNED OFF UPON TERMINATION.