Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

Flexible Spending Account REIMBURSEMENT REQUEST

Please staple receipts to back of form

This form should not be used for Benny card substantiation requests or HRA claims.

EMPLOYEE INFORMATION

Employee Name	Social Security #
Employer	Plan Year

DEPENDENT CARE (Child Care, Elder Care)

Provider Name	Provider SS # or Tax ID #	Services for (Name)	Relationship/Age	Dates of Service	Amount
				TOTAL ▸▸	

DEPENDENT CARE PROVIDER (if you don't have a receipt, this section must be completed)

Provider's Name			Provider's Social Security #/Tax ID #
Provider's Address Street	City	State	Zip
I certify that I have provided the services as listed above. Provider's Signature X			Date

MEDICAL CARE (You may copy form if needed for additional expenses or attach an itemized list)

Provider Name	Service(s)/Item(s) Purchased	Services for (Name/Relationship)	Date of Service	Amount
Mileage Reminder	You are eligible for reimbursement for mileage to and from an eligible medical appointment.		Number of miles x 0.165	
			TOTAL ▸▸	

I request reimbursement for my dependent care and/or medical care expenses as itemized above. Enclosed are receipts which state: Date of service, provider name, type of service, and fee charged for the service. My signature below acknowledges my understanding of the following: 1) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source. 2) The expenses must qualify for reimbursement under the Internal Revenue Code. 3) Reimbursed expenses cannot be claimed as credits or deductions on my personal income tax. 4) Participation in a Medical FSA may disqualify me and/or my spouse from participation in a Health Savings Account (HSA). 5) I have retained copies of the documentation submitted with this request as these materials will not be returned to me. 6) The expenses listed above were incurred by myself and/or my eligible dependents as defined by the IRS.

Signature Required ▸▸	Date

Reimbursement requests must be received before 12 Noon (ET) on Tuesdays for processing that week. Requests received after this time will be processed the following week. You may e-mail your completed claim form and required documentation (receipts) to: claims@gdynamic.com

E-MAIL TO: claims@gdynamic.com
MAIL TO: Group Dynamic, Inc. Reimbursement Benefits, 411 U.S. Route One, Falmouth, ME 04105
FAX TO: Reimbursement Benefits at 207-781-3841
PHONES: 207-781-8800 • MAINE 800-564-FLEX • US 800-626-FLEX
WEBSITE: www.gdynamic.com

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INSTRUCTIONS

DEPENDENT CARE EXPENSES

1. **Complete all pertinent information on the Reimbursement Request Form.** If you have any questions or need assistance in filing this form, please call 1-800-564-3539 within Maine or 1-800-626-3539 from elsewhere in the U.S. We will be happy to assist you.

2. Attach a copy of the invoice showing the provider's name and address, dates of service, and the expense incurred. If your daycare provider does not issue statements, you may complete the information on the front of the Request Form. Simply have your provider sign the form in the appropriate space as verification of the information that you have provided.

3. Third party verification is required; therefore, canceled checks, check copies or credit card statements may not be used as documentation.

4. Retain originals of the invoice(s) and Request Form submitted for your personal tax records, as those you submit cannot be returned to you.

5. Incomplete Reimbursement Request Forms or those lacking proper documentation will not be processed. You will receive a letter of explanation.

MEDICAL CARE EXPENSES

1. **Complete all pertinent information on the Reimbursement Request Form.** If you have any questions or need assistance in filing this form, please call 1-800-564-3539 within Maine or 1-800-626-3539 from elsewhere in the U.S. We will be happy to assist you.

2. Attach copies of the invoices for services received. The documentation submitted must include the provider's name, address & credentials, dates of service, description of service and the expense incurred.

3. If a service has been partially covered by insurance, send a copy of the Explanation of Benefits (EOB) received from the insurance company. Request only the amount you will actually be paying. You cannot be reimbursed for items that will be paid by your insurance.

4. Third party verification is required; therefore, canceled checks, check copies or credit card statements may not be used as documentation.

5. Retain originals of the invoice(s) and Request Form submitted for your personal tax records, as those you submit cannot be returned to you.

6. Incomplete Reimbursement Request Forms or those lacking proper documentation will not be processed. You will receive a letter of explanation.

7. In certain instances, a statement from your health care provider may be necessary to verify the medical necessity of a procedure or prescription.

Medical FSA Eligible Expenses

The list below includes generally eligible IRS Code Section 213 expenses. **Items marked with a ★ require a copy of a current prescription (written on a prescription pad). The prescription must be submitted each time a request for reimbursement is submitted for these items.**

REMEMBER:

1. All services must be provided by a licensed practitioner.
2. Stockpiling of supplies is prohibited by the IRS.
3. Services must be rendered or items purchased during the plan year (or grace period, if applicable).
4. You must use your flex account money during the plan year (or grace period, if applicable) or it is forfeited.

Acupuncture
Alcoholism treatment program fees
Allergy medicine ★
Ambulance service
Antacids ★
Anti-Diarrhea medicine ★
Artificial limbs

Bandages
Braille books and magazines *(above the cost of regular print)*

Car Modifications for equipment installed for the use of a person with a disability
Childbirth classes *(mother's costs only)*
Chiropractic care
Christian Science practitioner fees
Co-insurance charges
Co-payments
Cold medicine ★
Cold/Hot packs for injuries
Contact lenses *(including cleanser and saline solution)*
Cough drops ★
Crutches

Deductible expenses
Dental expenses *(non-cosmetic services only)*
Dentures
Diabetic supplies
Dietary Supplements ★
Drug addiction treatment at a therapeutic center

Eye drops ★
Eye exams
Eyeglasses

First aid kit

Gauze pads
Guide dog or other animal used by a person with a physical disability

Hearing aids/batteries
Hemorrhoid medications ★
Herbs ★
Hospital fees

Immunizations
Incontinence supplies
Insulin

Lasik Surgery
Laboratory fees
Laxatives ★
Learning disability *(fees paid to a special school or a specially trained tutor for a child with severe learning disabilities caused by mental or physical impairments, provided that the child's physician recommends that the child attend the school or be tutored)*

Massage therapy *(only if prescribed by a physician for a specific diagnosis and provided by a licensed massage therapist)*
Medical services provided by physicians, surgeons, and specialists *(non-cosmetic services only)*
Mileage related specifically to transportation to/from an eligible medical appointment
Motion-sickness medications ★

Nasal Spray ★
Nicotine gum or patches ★

Ointments for muscle or joint pain or for first aid purposes ★
Operations
Optical care provided by Optometrists, Ophthalmologists or Opticians
Organ transplants
Orthodontics
Orthotic Inserts
Osteopathic treatment
Oxygen

Pain relief medications ★
Physical exams *(unless employment related)*
Physical therapy
Prescription drugs
Prosthesis
Psychiatric care
Psychoanalysis
Psychological treatment
Pre-natal vitamins ★
Pregnancy test kits

Reading glasses
Rubbing Alcohol ★
Radial Keratotomy

Sales tax payable for eligible services or items
Sinus medicines ★
Smoking cessation programs
Special foods *(prescribed by a physician at costs in excess of the costs of commonly available products)*
Special schools for a mentally impaired or physically disabled person if the primary reason for using the school is its resources for relieving the disability *(e.g. a school that teaches Braille to a visually impaired child or teaches American Sign Language to a hearing impaired child)*
Suppositories ★

Thermometers

Vaccines
Vitamins ★

Wheelchair costs

X-rays

THIRD PARTY ADMINISTRATION

JAN 2011 REV

Want to view your account online? Use these instructions

Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

www.gdynamic.com

HOW TO VIEW YOUR ACCOUNT ACTIVITY ONLINE

1. Visit www.gdynamic.com. Select "Participant Login."
2. Below is the screen you will see when you select Participant Login.
2. First-time users: enter your Social Security Number as your user name and your GDI-assigned PIN as your password. Create your own username and password.

Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

Participant Online Inquiry

Welcome to our Online Participant Inquiry!

Sign in below by entering your User Name and Password.

If you have already established your unique user name and password, please enter them below.

For your initial use, use your Social Security Number or Alternate ID, if applicable, as your User Name and Personal Identification Number (PIN) as your Password. Enter your Social Security Number or Alternate ID without hyphens.

- Click here for detailed instructions.

- Please call our Reimbursement Team at 1-800-626-3539 if you need assistance with this process.

Log In
User Name
Password
Login

SECURE

Forgot Your Password?
Change Your Password?

Privacy Notice Terms of Use Technical Notice Login
Contact us

Help Tips

Please call our Reimbursement Team at 1-800-626-3539 with any questions you may have. If you have a Retiree Medical Account and require assistance please call 1-877-665-2727.

First time users follow these instructions.

This is where you login each time you would like to view your account.

Help is available!

Done Internet 100%

February 1, 2011