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

SPENDING ACCOUNT CLAIM FORM

____ Health Care Expenses

____ Day Care Expenses

**Please fill out every question from 1 through 4. Thank you.

1. Name_____

2. Social Security Number _____ Department _____

3. How are you paid? (Check only one) Bi-weekly _____ Monthly _____ 10-Month _____

4. Where would you like your check mailed? (Check only one) Home _____ Department _____

(If you are requesting your check at home, please verify your home address here:_____
_____)

List of Expenses:

List each service provided and attach bills, statements, or other evidence of these expenses (a cancelled check nor a credit card receipt alone is not sufficient evidence regarding services rendered).

Date of Service	Payment made to	Service provided (Medical, Dental, Vision, Day Care)	Amount

Total Expenses Claiming: $ 0.00

Signature:
I certify that the above expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. My health care plan or any other health care plan such as my spouse's has not reimbursed these expenses. 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 $5,000.00 from all employer sponsored dependent care spending account plans.

Signature: _____ Date: _____

For Human Resources ONLY

Claim Number: _____ Amount: _____

Claim Category: _____ Total: _____

Health Care Expenses

Health care expenses are expenses incurred by you, for 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.

Eligible health care expenses:

- Amounts that are not paid by the medical and dental plans, such as deductibles, coinsurance and amounts in excess of plan limits.
- The cost of eye examinations, frames, lenses, contact lenses, hearing examinations and hearing aids.
- The cost of prescription medicine and drugs including birth control pills and insulin.
- The cost of transportation primarily for and essential to medical care. Amounts paid for lodging while receiving medical care away from home, up to $50.00 per person per day.
- The cost of attending a special school for mentally or physically handicapped persons.

Ineligible health care expense:

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

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 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.

Eligible dependent care expenses:

- Amounts paid to a babysitter, or nurse, or licensed day care center.
- Amounts paid for services performed outside your home for the card of you dependent or spouse. If the care is for handicapped dependent that is age 13 or older, that dependent must spend at least 8 hours each day in your home.
- The full amount is paid to a nursery school, including school-provided meals and educational services.
- The full amount paid to a housekeeper, maid or cook, when regular duties include dependent care provided to a qualifying individual.
- Amounts paid to a relative who provides dependent care services, if the relative is not your or your spouse's dependent, and is not your child or stepchild who is under age 19 at the end of the year.

Ineligible dependent care expense:

- The cost of food or clothing.
- The cost of tuition for children in the kindergarten or higher.
- The cost of transportation between your house and the place where dependent care services are provided.
- The cost of overnight camping or nursing home facilities.
- Expenses for which a dependent care tax credit is taken.

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
- The lesser of your earned income or 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 is you have one eligible dependent, $400 for two eligible dependents.

In addition, you are required to report, on your federal income tax return, the name and 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 ID 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.

Return Claim Forms To:

Vickie Desormeaux
Human Resources
Rm. 170 Martin Hall

Or Mail To:

P.O. 40196
Lafayette, LA 70504