STATE OF MINNESOTA

REIMBURSEMENT REQUEST FORM
MDEA, DCEA & HRA

Benefit Year: ______________________ **State Employee ID Number:** ______________________

First Name: ______________ **MI:** ________ **Last Name:** ______________________

Address: ______________________ **City:** ______________ **State:** ______ **ZIP:** ________

Daytime Phone: (_____)______________________

Please verify that the mailing address above is current with the State. Address changes cannot be accepted via reimbursement forms.

Complete the information below for expenses incurred by you, your spouse, or other eligible dependents for which you request payment. See reverse side for complete instructions. **If the form is incomplete it will be returned to you and your reimbursement will be delayed.** Print or type the information requested, then date and sign the form. Keep a copy of all documentation for your records. **There is a $50.00 minimum reimbursement amount** except for claims filed after the last week of the plan year.

Unreimbursed Medical/Dental Expense (for you, your spouse and your dependents)

	Date(s) of Service (MM/DD/09)	Person for Whom Expense Incurred	Expense Description	Name of Service Provider	**Net Amount***
1.					
2.					
3.					
4.					
5.					
6.					
7.					
				Total Unreimbursed Medical/Dental Expense Claimed	$

Note: If you need additional space, attach a separate sheet of paper.

**Net Amount is the amount of the claim not reimbursed to you through another plan: for example, through health or dental insurance.*

Unreimbursed Dependent Care Expense (Daycare Expenses)

	Period Covered from (MM/DD/YY) to (MM/DD/YY)		Name of Dependent	**Identify below the Provider Name, Tax ID and Signature *OR* attach a receipt from the Provider with the Provider Name, Tax ID and Signature. The information is required with each submission.**	**Actual Amount Incurred**
8.				Provider Signature -	
9.				Provider Signature -	
				Total Unreimbursed Dependent Care Expense Claimed	$

Note: If same Dependent Care Provider for each claim listed above, signature is required only once.

Read Carefully

I certify that all expenses, for which reimbursement is claimed on this form, **were incurred during a period while I was covered under the cafeteria plan for the State of Minnesota.** I fully understand that I alone will be responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which I am submitting. If an expense for which I am claiming reimbursement is an improper expense under the plan, I may be liable for payment of all related federal, state, or city income tax on amounts paid from the plan which relate to such expense.

* Do not include MDEA or HRA reimbursement requests that have been paid through your MDEA/HRA debit card.

______________________________ ______________________

EMPLOYEE PLEASE SIGN HERE **DATE**

Plan Year January 1, 2009 through December 31, 2009. Final deadline for claims is March 1, 2010.

Send or fax this form with documentation to: **Eide Bailly Employee Benefits**

5601 Green Valley Drive Suite 710 **Or Fax to 952.918.3622**

Minneapolis, MN 55437-1145

A Reminder Regarding Reimbursable Medical/Dental Expenses

1. Reimbursement is based upon the incurred date not the paid date. **You "incur" an expense on the date that the service is received, not when you pay the bill.** You must provide proof that the expenses were incurred by attaching a statement from the provider indicating the date of service, a description of the service, and the charge for the service. Examples of acceptable documentation for healthcare expenses are an itemized statement or an insurance company's explanation of benefits (EOB). ***Do Not*** send canceled checks, copies of checks, credit card receipts or statements, a predetermination or estimate of insurance benefits form, balance-forward statements, or balance due statements of expense. **Keep a copy of the documentation for your records.** There is a fee for retrieval and copying of previously processed claims. For prescription medications you must include a copy of the pharmacy drug label or pharmacy statement showing the name of prescription(s)**. For over-the-counter medications you must submit a third party receipt with the name of the medicine or drug, the date purchased, and the amount paid.** Reimbursable over-the-counter items must be used to treat a medical condition, not for personal comfort or general well being.

2. You can use the Medical/Dental Expense Account (MDEA) for the reimbursement of any eligible expenses not paid in full by another plan or for any eligible expenses not covered by your health plan. To be eligible, expenses must meet the following requirements:
   - They must be directed or prescribed by a physician or dentist
   - They must be directly related to a physical or mental condition
   - Expenses must be incurred on or after the effective date of the plan and after the date you become a plan participant
   - Expenses must be incurred by you, your spouse, or other person who qualifies as an eligible dependent for federal income tax purposes

3. Examples of eligible expenses:
   - Deductibles (the part of covered expenses you pay before your health plan pays any benefits)
   - Co-insurance amounts (the percent of covered expenses you must pay, if any, after the deductible requirement has been met)
   - Dental expenses such as exams or other services
   - Vision care expenses such as eye examinations and eye glasses
   - Hearing care expenses, including hearing examinations and hearing aids
   - Routine physical examinations
   - Prescription and over-the-counter medicines to alleviate or treat a medical condition
   - Co-pays

A Reminder Regarding Reimbursable Dependent Care (Daycare) Expenses

1. For your dependent care expenses to qualify for reimbursement from the Dependent Care (Daycare) Expense Account, (DCEA) the following requirements must be met:

   - Your spouse must be working for pay, attending school, or seeking employment while you are at work.
   - Children receiving daycare must be under the age of 13 at the time the daycare services are provided, or the person receiving care must be physically or mentally incapable of self-care.
   - The provider cannot be listed as a dependent on your federal income tax form, and if the provider is your own child, your child must be at least 19 years of age.
   - An unlicensed care provider must care for no more than six children (excluding full-time residents of the daycare facility).
   - Expenses must be incurred on or after the effective date of the plan and after the date you become a plan participant.
   - Under federal law, when you file your income tax return with the IRS you must also report the name, address, and taxpayer identification number of all providers of dependent care services whose fees were reimbursed to you under this plan during the year. Failure to do so constitutes tax fraud **unless** the provider of these services is a 501(c)(3) tax-exempt organization. If you have questions on how this might affect your tax filing, refer your question to your tax advisor.

2. If the amount of daycare expense reimbursement you receive for a calendar year exceeds your earnings and you are single or the earnings of the lower-paid spouse if you are married, the difference must be reported as taxable income for the year. There are special rules if your spouse is a full-time student or is physically or mentally incapable of self-care. Again, see your tax advisor if you have questions.

3. You must provide proof that the expenses were incurred either by having the provider complete the Provider Signature section of the form or by attaching an itemized statement from the provider. Indicate the actual amount incurred, not the amount you calculate to be in the account.

4. If there is not enough money in your DCEA to cover in full the eligible expenses listed on this form, you will be reimbursed up to the amount of your account balance and the excess expenses will be carried forward and paid from the contributions you make in subsequent periods. You do not have to re-submit the charges.

Notice Regarding Collection of Private Data

Under provisions of Minnesota Statutes 43A 22-24, Eide Bailly Employee Benefits has been authorized to administer the State of Minnesota Pre-tax Benefits Plan. Information is requested on this form about you, your family members and your expenses to identify you as a participant in the Plan and to determine your eligibility for expense reimbursements. You are not legally required to provide any information requested. However, providing all the requested information will help to process your claim accurately and quickly. If you do not provide critical information, we may be unable to process your reimbursement request. The information requested may be provided to: representatives of the Minnesota Management & Budget, federal and state tax authorities, professional auditors who audit the State of Minnesota Pre-Tax Benefits Plan, law enforcement entities with statutory authority to gain access to the data, and any other person or entity authorized by law or court order.

Questions Regarding the Reimbursement Process?

For toll-free support, call Eide Bailly Employee Benefits at 1-800-300-1672 or from the Twin Cities Metro area, call 952- 944-6633. When calling, please identify yourself and your employer, and have available your State Employee ID Number.