SAINT MICHAEL'S COLLEGE FLEXIBLE BENEFITS PLAN

Health Care Expense Claim Form

Name (last, first, MI)

The undersigned Participant in the Plan requests reimbursement in the amount shown below (please list individually on the reverse side):

Please attach the following documentation for each expense (a cancelled check or credit card receipt /statement is not considered acceptable evidence):

- **Services or products covered by any other benefit plan** (i.e., health insurance plan)**:** Explanation of Benefits Statement (EOB), or
- **Services or products NOT covered by any other benefit plan:** invoices or receipts which indicate the name and address of the service provider, name of employee or dependent for whom the service was provided, date of service, type of service or product provided and amount of expense.

Total Amount of Medical Expenses (from page 2 of this form):

IMPORTANT

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment are claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Saint Michael's College Flexible Benefits Plan with respect to such expenses and that such 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 the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made. Furthermore, the undersigned agrees that any amounts paid which are in excess of his or her current account balance will be considered a loan and will be owed to the Plan in the event he or she terminates employment (for any reason) prior to the completion of the current Plan Year.

Participant's Signature	**Date**

Please return completed form to: Future Planning Associates, Inc.
ATTN: Saint Michael's College Administrator
600 Blair Park Road**, P.O. Box 905**
Williston, Vermont 05495-0905
FAX: *802/878-9455 – If Faxing this request, to avoid duplication****, DO NOT*** *mail.*

☐ Direct Deposit for Claims Reimbursement is available -- check this box and complete the "Employee Authorization Agreement for Direct Deposit..." and send to Future Planning Associates, Inc.

•only one request is needed to implement this service•

· This form must reach Future Planning Associates, Inc. by noon on the 25th of the month ·
· Disbursements are paid the following month ·

Itemized List of Expenses
Health Insurance Premiums are NOT a permitted Health Care expense

Date Incurred	Name of Service Provider	Description of Expense	Person for Whom Expense Incurred	Net Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
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				$
				$
				$
Total (enter here and on page 1 of this form)				$

EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF HEALTH CARE AND DEPENDENT CARE REIMBURSEMENTS

I hereby authorize and request that Future Planning Associates, Inc. (contracted by Saint Michael's College to provide administration services for the Saint Michael's College Flexible Benefits Plan) to make payment of any Saint Michael's College Flexible Benefits Plan Claims Reimbursement of any amounts to me by initiating credit entries to my account indicated below in the bank named below, hereinafter called BANK, and I authorize and request BANK to accept any credit entries initiated by Future Planning Associates, Inc. to such account and to credit the same to such account without responsibility for the correctness thereof.

I also authorize Future Planning Associates, Inc. to adjust any over deposits erroneously credited to my account if prior to the initiation of the correcting entry, Future Planning Associates, Inc. has sent or delivered to me written notice of the correction.

It is understood that this agreement may be terminated by me at any time by written notification to Future Planning Associates, Inc. Any such notification to Future Planning Associates, Inc. shall be effective only with respect to entries initiated by Future Planning Associates, Inc. after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my account by BANK after receipt of such notification and a reasonable time to act on it.

I recognize, acknowledge and accept that this service is being provided for my convenience. As such, I agree not to hold Saint Michael's College and Future Planning Associates, Inc. liable for errors made by them or the financial institution.

ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR SAVINGS ACCOUNTS

Name of Bank or Credit Union * ____

Account # ______________________________ Routing # ______________________________

* Contact your Credit Union to verify your "Account" and "Routing" Numbers

Account Type: ______ Checking **(attach ONLY a voided check, a deposit slip is not sufficient when selecting a checking account)**

______ Savings **(attach a deposit slip)**

Employee Name (Print)____

Employee Signature: ____

NOTE: Any changes in Bank or Account Numbers must be made in writing and sent to:

Saint Michael's College Plan Administrator
Future Planning Associates, Inc.
600 Blair Park Road, **P.O. Box 905**
Williston, VT 05495-0905
Phone: (802) 878-6601 **FAX:** (802) 878-9455