Citizens Memorial Healthcare will be offering the Medical Flexible Spending Account (maximum of $2,500) and Dependent Care Spending Account (maximum of $5,000 or $2,500 if married and filing single) benefits for the 2016 Plan Year. Note the Highlights below:

- The Plan Year is January 1st, 2016-December 31st, 2016. Citizens Memorial Healthcare has agreed to allow a 2 ½ month extension to file claims, therefore, claims must be incurred by March 15th, 2017 and submitted by March 15th, 2017.

- Services must be incurred during the Plan Year and while you are active on the Flexible Spending Account. Employees who terminate employment during the Plan Year have until the end of the month in which they terminate to submit a claim for eligible expenses incurred prior to their date of termination.

- Reimbursements are made every Thursday for claims received Wednesday by 3:00pm. Claims can be filed by email, fax or mail:

  HealthSmart Benefit Solutions
  Attention: April Tennell
  April.Tennell@HealthSmart.com
  300 SE Frank Phillips Blvd. Suite 200
  Bartlesville, OK 74003
  Phone: (800) 824-5034
  Fax: (866) 513-9681

Flex Spending Website is: www.maa-tpa.com (new members click on the Flex Account Login after 1/1/2016 to register).

To expedite you claim:

- Provide *all appropriate information.*
- *Review the Total Dependent Care and Total Medical Care Expense Amounts before printing.*

Citizens Memorial Healthcare

Flexible Benefit Plan Reimbursement Claim Form

Employee Name: _____ E-mail: _____

Phone: _____

Dependent Care Expense Claims

Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
Attach a receipt from your daycare provider, or include the daycare provider's signature.			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	**$**

*NOTE: 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 himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, or $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.

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.		**Total Medical Care Expense Claim**		**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical 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 expense.

_____ _____

Employee's Signature Date

Contact Info:

Name: April Tennell
Phone: (800) 824-5034 (Toll Free)
(918) 335-0387 (Bartlesville, OK)
Fax Claims: (866) 513-9681
Email Claims: atennell@bmi-healthplans.com
Mail Claims: 300 SE Frank Phillips Blvd. Suite 200
Bartlesville, OK 74003
Website: www.maa-tpa.com

To expedite you claim:

- Provide *all appropriate information.*
- *Review the Total Dependent Care and Total Medical Care Expense Amounts before printing.*

AUTHORIZATION AGREEMENT-FSA
DIRECT DEPOSIT (ACH CREDITS)

I _____, hereby authorize Citizens Memorial FSA, hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit and/or debit the same to such account.

_____
(Financial Institution Name)

_____
(Address) (City/State) (Zip)

_____ _____
(Routing Number) (Account Number)

Type of Account: _____Checking _____Savings

PLEASE ATTACH COPY OF VOIDED CHECK HERE

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

_____
(Print Individual Name)

_____ _____/_____/_____
(Signature) (Date)

To expedite you claim:

- Provide *all appropriate information.*
- *Review the Total Dependent Care and Total Medical Care Expense Amounts before printing.*