

Number of pages faxed

WageWorks, formerly Creative Benefits
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 PHONE: Toll free (888) 295-5656

Claim forms and supporting documentation received prior to 2:00 p.m. Pacific Time, are processed the same day.

Spending Account Claim Form

SECTION A - EMPLOYEE INFORMATION

Name _____
(Print or type: Last, First, Middle Initial)

Mailing Address _____

City, State, Zip _____

Daytime Phone # (_____) _____

Email Address _____

If you have an address change, be sure to update your records with your employer.

Is this a new address? (check one) YES NO

Social Security # _____
 or your Participant ID # _____
as assigned by WageWorks, formerly Creative Benefits

Employer _____

Please send photocopies of forms and documents. Keep originals for your records, as claim and supporting documentation become part of this claim record and cannot be returned to you. Receipt of faxed claims cannot be verified due to our large volume. Please call the automated system at (888) 295-5656 after 5p.m. Pacific Time or go online to www.creativebenefits.com to determine if your claim has been received and entered.

SECTION B - EXPENSES TO BE SUBMITTED (If you are a Spending Account Payment Cardholder, check payment card box and enter a \$0 in the amount of expense column if submitting supporting documentation for payment card usage.) Attach copies of supporting documentation from your third party provider describing the services and for whom were rendered, date(s) of services (for Dependent Day Care, supporting documentation must indicate "from and to" dates of service as well as the daycare provider's information) and amount paid (such as all invoices, receipts or other supporting documentation). **The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, credit card receipts or statements are NOT acceptable documentation of expenses.**

You can also file your claim online at our secure site at www.creativebenefits.com, print a confirmation sheet and fax it to us with your third party supporting documentation.

spending account payment card	expense type (check only one per row)		expense description	person for whom expense was incurred	relationship (spouse, child or tax dependent)	date of birth <small>Format dates: mm/dd/yy</small>	dates of service (from - to) <small>Format dates: mm/dd/yy</small>	amount of expense
	Health	Day Care						
<input type="checkbox"/>								\$
<input type="checkbox"/>								\$
<input type="checkbox"/>								\$
<input type="checkbox"/>								\$
<input type="checkbox"/>								\$
<input type="checkbox"/>								\$

The day care provider's signature can be substituted for the supporting documentation.

TOTAL amount to be reimbursed \$ _____

➔ **DAY CARE PROVIDER'S SIGNATURE** _____

At the end of the tax year, you are required to provide IRS with the name, address and Tax ID# on Tax Form 2441 in order to obtain the tax advantage for these expenses.

SECTION C - EMPLOYEE CERTIFICATION

I certify that: I have not been reimbursed and will not seek reimbursement for these same incurred expenses under any other plan and cannot claim these same expenses for an income tax deduction. All of these incurred expenses qualify as eligible expenses for myself and/or my eligible dependents in accordance with the Plan and IRS Regulations. If I have included an over-the-counter medicine, drug or supply, I certify that it is being used "to diagnose, cure, mitigate, treat or prevent disease, or for the purpose of affecting any structure or function of the body." If the over-the-counter item is a supplement, herbal remedy or vitamin, I certify that it is being used for medical care as defined above with the advice of a licensed health care practitioner and not simply to promote general health and have attached the physician's statement. I understand that certain over-the-counter remedies may require additional certification from my health care practitioner. By providing my email address, I am requesting all communications regarding my spending account sent to me via email.

SIGN AND DATE FORM EACH TIME ➔

I certify this claim in accordance with Section C - Employee Certification. Unsigned claims will automatically be denied.

PARTICIPANT SIGNATURE _____ **DATE** _____

HEALTH CARE SPENDING ACCOUNT - ELIGIBLE EXPENSES (Check your Summary Plan Document for details or limitations.)

Services by an M.D. or Licensed Practitioner when medically necessary, including:

- Acupressurist
- Acupuncturist
- Anesthesiologist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Midwife
- Obstetrician
- Ophthalmologist
- Optometrist
- Osteopath
- Pediatrician
- Podiatrist
- Psychiatrist/Psychologist
- Psychotherapist
- Surgeon

Medical/Hospital services or other fees:

- Diagnostic services by or under direction of M.D.
- Surgical services by or under direction of M.D.
- X-rays and radiological services for diagnosis or treatment
- Expenses for donating or receiving an organ transplant
- Nursing services for specific medical ailments by an RN or LPN who is not related to employees
- Services of a physical, speech or an occupational therapist
- Ambulance
- Laboratory fees
- Prescription drugs: including insulin, laetrile and birth control pills
- Over-the-counter drugs, medications and supplies.* Only a quantity of six may be purchased at a time.
- Vaccinations and immunizations
- Orthotics
- Special schooling for physically or mentally disabled dependents
- Transportation and lodging expenses incurred for medical reasons
- Legal fees paid to authorize treatment for mental illness
- Deductibles and copayments

Other health-related expenses

- Treatment of alcoholism or drug dependency, including expenses for meals and lodging at a treatment center
- Lead-based paint removal in the home
- Smoking cessation programs and related drugs

* If used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body

Dental, vision & hearing

- Dental checkups and care (by a DDS or dental hygienist), including dentists' fees, X-rays, fillings, braces, extractions and dentures
- Orthodontics (usually the pro-rated cost attributable to this plan year)
- Cost of guide dog for blind or deaf
- Braille books and magazines (in excess of regular book cost)
- LASIK, Laser, RK surgery or PRK surgery, prescription eyeglasses and contact lenses (including solutions)
- Special devices for the blind (tape recorder, typewriter)
- Hearing aids and care (including batteries)
- Cost of note-taker for a deaf person in school
- Household visual alert & expenses for special phone equipment for a deaf person
- Adapting a television for the deaf

Maintenance & support devices (these require a letter of medical necessity from a licensed physician)

- Support hose and orthopedic shoes (in excess of regular shoe cost)
- Wheelchairs, crutches and wigs for hair loss due to medical treatment
- Oxygen and oxygen equipment
- Cost of equipping an auto for the disabled (in excess of regular auto cost)
- Prostheses and prosthetic supplies
- Colostomy supplies
- Capital expenses - the amounts between the cost of improvements or special equipment installed and the increase in the value of the home
- Psychiatric care - may include costs of supporting mentally ill dependents at a specially equipped center where a dependent receives medical care
- Massage therapy

Miscellaneous (requires a written directive from a licensed practitioner)

- Vitamins and dietary supplements. Quantity of six maximum per purchase.

INELIGIBLE EXPENSES (Health Care)

- Athletic or health club membership
- Cosmetic procedures and/or surgeries
- Household help
- Any illegal treatment
- Prepayment for services
- Dancing or ballet, even when recommended by a doctor
- Cost of remedial reading classes for a non-handicapped child
- Insurance premiums of any type
- Weight reduction programs for general well-being
- Teeth bleaching or whitening
- Marriage counseling
- Toiletries and sundry items (such as toothpaste, shaving cream, deodorant, shampoo, makeup)
- Electric toothbrushes
- Sunscreen under SPF 30
- Insect repellent

DEPENDENT CARE SPENDING ACCOUNT - ELIGIBLE EXPENSES (Check your Summary Plan Document for details or limitations.)

- Before and after school care
- Preschools
- Day care centers (facilities that care for 6 or more children must be licensed)
- Day camps (including summer and holiday)
- Services provided by someone who is not your minor child, dependent for income tax purposes, or the parent of the child
- Registration and application fees
- Au pair or nanny
- Transportation – to or from where care is provided, if furnished by day care provider
- Sick child facility
- FICA and FUTA taxes of day care provider

INELIGIBLE EXPENSES (Dependent Care)

- Kindergarten tuition
- Overnight camps
- Prepayment for services
- Late payment fees
- Incidental expenses such as meals, activity charges, supply fees, equipment fees, uniforms (when separate from care)

This list is not intended to be a guarantee of reimbursement or eligibility. All claims are reviewed when they are received and the determination of eligibility or reimbursement is made based upon the information received from the plan participant.