J. J. STANIS AND COMPANY, INC.

377 OAK STREET, SUITE 406
GARDEN CITY, NY 11530
516-465-3900 PHONE
516-465-3920 FAX

Re: Health Flexible Spending/Dependent Care Account

Dear Participant,

This packet was designed to aid in the election and participation of the flexible spending portion of the Section 125 Flexible Benefit Plan sponsored by your employer. The amounts you elect to be set aside for your Health Flexible Spending Account (Health FSA) and/or your Dependent Day Care FSA will be in-force for the 1/1/2016 through 12/31/2016 plan year. Your employer will announce the new election limits for 2016.

The following sections are included in this booklet:

- How Flexible Spending Accounts Work
- How to File a Claim
- What eligible expenses will be considered
- Enrollment Forms
- Reimbursement Forms

For additional reimbursement forms, please visit our web site at: www.jjstanisco.com

We look forward to assisting you with your Flexible Spending Account(s).

Sincerely,

J.J. Stanis and Company, Inc.
Section 125/Flex Administration

For helpful hints and an at-a-glance overview of how to submit your Flexible and/or Dependent Care claims please see Page 6 of this packet.

How Flexible Spending Accounts Work

Flexible Spending Accounts allow you to direct a part of your pay, on a pre-tax basis, into special accounts that can be used throughout the year to reimburse yourself for certain out-of-pocket medical expenses and/or dependent day care expenses. Because your money goes into your reimbursement accounts before federal and state income taxes are withheld, you pay less in taxes, and ultimately have more disposable income. There are two separate accounts: a Health FSA and a Dependent Day Care FSA.

Health Flexible Spending Accounts

Your Health FSA may be used to reimburse eligible medical, dental, vision, etc. expenses incurred for yourself, your spouse, and your eligible dependents (minus amounts reimbursed by insurance) up to the maximum benefit amount you elected for the year. (Please see Page 2A for your employer's minimums and maximums for the 1/1/2016 through 12/31/2016 plan year). You may only be reimbursed for expenses incurred for services rendered during the plan year, not for services rendered in a different plan year but paid in the current plan year. If you are a new employee entering the plan during a plan year, services must be rendered after you are eligible to participate in the plan. Participants are allowed a 90-day run-off period after the plan year ends in which to submit claims that occurred during the plan year but were not yet submitted (run-off period may vary).

What Expenses are Eligible for Reimbursement?

Effective 1/1/2011, healthcare FSA's are prohibited from reimbursing expenses for over the counter (OTC) drugs and medications unless the purchase was obtained by prescription. The documentation required for a reimbursement of a prescribed OTC drug/medicine is subject to IRS guidelines and applicable law. You will need a prescription to be reimbursed for such over-the-counter items such as cough medicine and aspirin. This new rule will apply only to medicines and drugs; it does not apply to non-drug medical expenses for example band-aids, crutches, contact eye solution. (A detailed list can be found on Pages 7 through 10 of this packet).

Premium Conversion Account

The purpose of this Plan is to allow employees to pay pre-tax contributions towards employer-sponsored health plans maintained by your employer. Participation in this plan is automatic unless you complete and submit a waiver form to your employer.

Dependent Care FSAs

An employee may contribute to a dependent care up to $5,000 ($2,500 for a married employee filing separate tax returns) of dependent care expenses each plan year. Reimbursable expenses are non-health care expenses that are incurred for the care of an eligible dependent so as to:

- Enable the employee, or the employee's spouse, to be gainfully employed or to attend school full-time. Gainful employment may be full or part-time, inside or outside of the home. Volunteer work does not meet the definition of gainful employment.
- Ensure a qualified dependent's well being and protection. Qualified dependents are children under age 13. Also considered to be qualified dependents are disabled spouses and other dependents who are physically or mentally incapable of self care, and who regularly spend at least eight hours each day in the taxpayer's household.

Herricks UFSD

Healthcare Reimbursement Account

Minimum Allowable: $200

Maximum Allowable: $2,550

Dependent Care Reimbursement Account

Minimum Allowable: $200

Maximum Allowable: $5,000

Dependent care FSAs may not reimburse employees for amounts paid to persons whom they claim as their own dependents for income tax purposes or for amounts paid to a child of their own who is under age 19 at the close of the tax year. Additionally, employees may not be reimbursed for amounts paid to camps where their dependents stay overnight -e.g., summer camp for children.

No Advance Payment for Dependent Care FSAs

Dependent care expenses may not be reimbursed until they are actually incurred - i.e., after the care has been provided, and not when the participant is formally billed, charged for, or pays for the dependent care. Thus, even though some day care centers require advance payment for services, employers may not reimburse employees for the expense until after the care has been provided - a situation that may cause cash flow hardship for some employees.

Furthermore, the dependent care account can only reimburse with funds deposited into the account (deductions withheld from your paycheck). If there are not funds available when you submit a claim, we will enter the claim into our system. As soon as additional funds are deposited, a check will be issued. If the amount of your expense was more than your account balance, the excess part of your claim will be carried over to the next pay period, to be paid out, as your account balance becomes adequate.

"Qualifying Day Care Center" means a day care center which provides full-time or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the Eligible Employee's taxable year, and which:

A. Complies with all applicable laws and regulations of the state and town, city or village in which it is located; and
B. Receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for profit).

"Qualifying Individual" means:

A. A Dependent of the Participant who is under the age of 13; or
B. A Dependent of the Participant who is physically or mentally incapable of caring for himself or herself
C. A Spouse of the Participant who is physically or mentally incapable of caring for himself or herself.

"Qualifying Services" means services performed:

A. In the home of the Participant; or
B. Outside the home of the Participant for

   (i) The care of a Dependent of the Participant under the age of 13, or
   (ii) The care of any other qualifying individual who spends at least eight hours a day in a participant's home

"Services" means the duties performed to enable a Participant or his Spouse to remain gainfully employed and which are related to the care of a Qualifying Individual.

"Spouse" means the person to whom the Participant is legally married but shall not include an individual legally separated from a Participant under a decree of legal separation.

"Student" means an individual who during each of five calendar months during a Plan Year is enrolled as a full-time student at an Educational Institution.

Terminating Employees

Employees who terminate their employment before the end of the plan year:

- May forfeit their account balances, by failing to request reimbursement in the grace period established by the employer.

Obligations under COBRA for Health Care

A health care FSA is considered to be a "group health plan" with respect to the health care continuation rules of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This means that employees who have terminated their employment and have a positive FSA balance have the right to elect to continue their participation in the health care FSA.

Risk-of-Lose Rule or "Uniform Coverage Rule" for Health Care FSAs

The uniform coverage requirement, sometimes called the risk-of-loss rule, requires health care expense FSAs to operate like insurance plans and demonstrate risk, rather than mere reimbursement accounts. This essentially means that employers must make the full amount of coverage elected by a plan participant available to the employee from the start of the plan year; regardless of how much to date has been contributed. Employer can limit their liability by setting a maximum in the health care FSA.

FSA Forfeitures

Because of the tax advantages of the Flex Spending Account, the Internal Revenue Service (IRS) has strict guidelines for its use. One of these guidelines is commonly known as the "use it or lose it" rule. Put simply, if you contribute pre-tax dollars into your Health Care FSA or Dependent Care FSA and then do not have enough eligible expenses during the Plan Year to equal the amount you contributed, you will lose the balance remaining in your account when the Plan Year ends. That is why it is important to plan carefully before deciding how much to contribute. With careful planning, you can minimize the risk of losing any of your contributions. According to the IRS, after all submitted reimbursement claims have been processed, any funds remaining must be returned to the employer.

Employers are not permitted to return funds directly or indirectly to employees that have remaining balances in their accounts at the close of the plan year.

Change of Status Criteria for Medical FSA and Dependent Care Accounts

In order to make a mid-year change of election in or termination of a participant's medical FSA or Dependent Care Account, the participant must have a change in family status falling into one of the following six categories:

- A change in the participant's legal married status
- A change in the participant's number of dependents
- A change in the work schedule of the participant or the participant's spouse
- Termination or commencement of employment of the participant's spouse
- An unpaid leave of absence taken by either the participant or the participant's spouse
- Significant change in the participant's or the participant's spouse health coverage as s result of the spouse's employment status

If such a qualifying event occurs and the participant wishes to make a change in his or her election (consistent with the resulting gain or loss of eligibility for coverage), the plan administrator must be notified within 30 days of the event. Changes are made effective the date the Change of Status form is filed with the plan administrator. To file a Change of Status form, please see your employer.

Claims Appeals

Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination. Participant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within 30 days following receipt of this notice, which must be in writing and addressed as follows:

J.J. Stanis and Company, Inc.
377 Oak St.
Suite 406
Garden City, NY 11530
ATTN: Claims Appeals

If participant provides the Plan will all information needed to address the appeal, the Plan will respond to the appeal not later than 30 days after receipt of the appeal. Participant are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits.

J.J. STANIS AND COMPANY, INC.

377 Oak St, Suite 406 • Garden City, New York 11530
Phone 516 • 465 • 3900 Fax 516 • 465 • 3920

Please read the following helpful hints to aid in the processing and expediting of your Flexible Spending and Dependent Care claim reimbursements ~

1. Attach a Claim Form

- Complete the Health Care or Dependent Care claim form and remember to Sign and Date it. If any information is omitted, it can cause a delay in processing your claim(s). (Please see the Claim Appeals section of this packet).
- Keep copies of all documentation sent in with your claim(s).

2. Include the (corresponding) Explanation of Benefits

- When filing for reimbursement of Medical, Dental and/or Vision expenses, please be sure to include the Explanation of Benefits from your Insurance company. If you do not have Insurance for the benefits on which you are seeking reimbursement, *please be sure to check off "I do NOT have insurance coverage for this expense"* on the Request for Healthcare Reimbursement Claim Form.
- Please Indicate on the Claim Form the description of service being submitted (I.e. Durable Medical Equipment, Contact Lenses, Office Visit co-payment; etc.)
- Please submit reimbursement claims for Healthcare and Dependent Care *after* the services are rendered and expenses are incurred.

3. Items submitted for reimbursement should be legible and contain the following information:

- Name of service provider
- Description of the service(s) being rendered or the name of the supplies furnished
- The charge(s) for each service and/or supply
- The date(s) for each service and/or supply
- The name of the person(s) receiving service
- Prescriptions must include the drug name as well as the above
- Dependent Care provider Tax Identification Number along with dates of service, and child or children's name receiving services

Time Saving Tip: Request a (prescription) printout from your pharmacy that lists all necessary information; eliminating the need to submit prescription "stubs"

4. Claim Filing Tips:

- Do not submit balance due statements or credit card receipts as they are not valid receipts. They must contain all of the information stated above.
- When possible, group expenses *per family member.*
- Separate claims by Plan Years. (I.e. group 1/1/15 through 12/31/15 expenses; group 1/1/15 – 12/31/15 expenses, etc.)
- Do not Hi-Light expenses or staple them together.
- Do not submit duplicate receipts.
- Include Letter(s) of Medical Necessity from your attending physician if submitting for durable medical equipment, supplies, vitamins; etc.
- Include the prescription(s) for Over-the-Counter medications.
- If you are submitting a photocopy, please be sure the copy is legible and contains all the information as the original.

J.J. STANIS AND COMPANY, INC.

EXAMPLES OF QUALIFYING HEALTH CARE EXPENSES (NOT ALL INCLUSIVE)

ABORTION
You may include in health care expenses the amount you pay for a legal abortion.

ACUPUNCTURE
You may include in health care expenses the amount you pay for acupuncture. It must be necessary to treat a specific medical condition.

ALCOHOLISM
You can include in health care expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment.

AMBULANCE
You may include in health care expenses amounts you pay for ambulance service.

ARTIFICIAL LIMB OR PROSTHESIS
You may include in health care expenses amounts you pay for an artificial limb.

ARTIFICIAL TEETH
You may include in health care expenses amounts you pay for artificial teeth.

BIRTH CONTROL
You may include in health care expenses, birth control pills prescribed by your doctor. You may also include the cost of condoms and spermicides.

BRAILLE BOOKS/MAGAZINES
You may include in health care expenses the part of the cost of Braille books and magazines for use by a visually impaired person that is more than the cost for regular printed editions.

BREAST PUMPS
You may include in health care expenses the cost of a breast pump if there is a medical reason. Expenses MAY NOT be included if only used for convenience, scheduling or other personal reasons. A note from an attending physician stating that a medical condition exists must be provided.

CAR
Special equipment. You may include in health care expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.
Special design. The amount by which the cost of a car specially designed to hold a wheelchair is more than the cost of a regular car is a health care expense.

CHIROPRACTORS
You may include in health care expenses fees you pay to a chiropractor for health care.

CHRISTIAN SCIENCE PRACTITIONERS
You may include in health care expenses amounts you pay to Christian Science practitioners if payments are for health care.

CONTACT LENSES
You may include in health care expenses amounts you pay for contact lenses needed for health care reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.

CRUTCHES
You may include in health care expenses amounts you pay to rent or buy crutches.

DENTAL TREATMENT
You may include in health care expenses amounts you pay for dental treatment. This includes fees paid to dentist, X-rays, fillings, braces, extractions and dentures.

DIAGNOSTIC DEVICES
You may include in health care expenses the cost of devices used in diagnosing and treating illness and disease (e.g. blood sugar test kits).

DOCTOR'S FEES
You may include in health care expenses amounts you pay for legal health care services provided by: physicians, surgeons, specialists, and other medical practitioners. You may also include amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill dependent at a specially equipped health care center where the dependent receives health care.

DRUG ADDICTION
You may include in health care expenses amounts you pay for inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

EYEGLASSES/EYE SURGERY
You may include in health care expenses amounts you pay for eyeglasses and contact lenses you need for health care reasons. You may also include fees paid for eye examinations. You may also include amounts you pay for eye surgery to treat defective vision.

FERTILITY ENHANCEMENT
You can include the cost of the following procedures to aid in having children.
- Procedures such as *in vitro* fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevents you from having children.

GUIDE DOG
You may include in health care expenses the cost of a guide dog for the visually impaired or hearing-impaired. Amounts you pay for the care of the dog are also health care expenses.

HEARING AIDS
You may include in health care expenses amounts you pay for hearing aids and the batteries you buy to operate it.

HOSPITAL SERVICES
You may include in health care expenses amounts you pay for inpatient care if the main reason for being there is to receive health care.

LABORATORY FEES
You may include in health care expenses amounts you pay for laboratory fees that are part of health care.

LEGAL FEES
You may include in health care expenses legal fees paid to authorize treatment for mental illness. However, you may not include fees for the management of a guardianship estate or other fees not necessary for medical care.

LODGING
You may include in health care expenses the cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive health care.

MEDICAL INFORMATION PLAN
You may include in health care expenses amounts paid to a plan that keeps your health care information in a computer data bank and retrieves and furnishes the information upon request.

MEDICINES OR DRUGS
Both prescribed and over-the-counter medicines or drugs are reimbursable if they are primarily for medical care. See separate sheet entitled "Allowable Expenses Under Health Care Flexible Spending Accounts to Include Over-The-Counter Medicines and Drugs" for information regarding over-the-counter medicines and/or drugs.

MENTALLY CHALLENGED, SPECIAL HOME
You may include in health care expenses the cost of keeping a mentally challenged person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from living in a mental hospital to community living.

NURSING HOME
You may include in health care expenses the cost of health care in a nursing home or home for the aged, or a similar institution, for you, your spouse or your dependents, if the main reason for being there is to get health care.

NURSING SERVICES
You may include in health care expenses wages and other amounts you pay for nursing services.

OPERATIONS OR SURGERY
You may include in health care expenses amounts you pay for legal operations that are not for cosmetic surgery.

OXYGEN
You may include in health care expenses amounts you pay for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition.

PSYCHOANALYSIS
You may include in health care expenses amounts you pay for psychoanalysis.

PSYCHOLOGISTS
You may include in health care expenses amounts you pay to a psychologist for health care.

SMOKING CESSATION PROGRAMS
You may include in health care expenses the cost of a program to stop smoking.

SPECIAL SCHOOLS
You may include in health care expenses payments to a special school for a mentally impaired or physically disabled person if the main reason for using the school is its resources for relieving the disability.

STERILIZATION
You may include in health care expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children).

TELEPHONE
You may include in health care expenses the cost and repair of special telephone equipment that lets a hearing impaired person communicate over a regular phone.

TELEVISION EQUIPMENT
You may include the cost of equipment that displays the audio part of a television program as subtitles for hearing impaired persons.

THERAPY
You may include in health care expenses amounts you pay for therapy you receive as medical treatment.

TRANSPLANTS
You may include in health care expenses payments you make for surgical, hospital laboratory and transportation expenses for a donor or a possible donor of a kidney or other organ.

TRANSPORTATION
You may include amounts paid for transportation primarily for, and essential to, health care.

WHEELCHAIR
You may include in health care expenses amounts you pay for an ambulette or wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work.

WIG
You may include the cost of a wig purchased on the advice of a physician for the mental health of a patient who has lost all of his/her hair from disease or as a result of medical care received for a disease.

X-RAY FEES
You may include in health care expenses amounts you pay for x-rays you get for medical reasons.

J.J. STANIS AND COMPANY, INC.

377 Oak St, Suite 406 • Garden City, New York 11530
Phone 516 • 465 • 3900 Fax 516 • 465 • 3920

EXAMPLES OF NON-QUALIFYING HEALTH CARE EXPENSES (NOT ALL INCLUSIVE)

BREAST IMPLANT REPAIR

COACH FOR CHILD BIRTH

CONTACT LENS INSURANCE CONTRACTS

COUNSELING FOR MARITAL OR RELATIONSHIP ISSUES

DANCING/SWIMMING LESSONS

DIAPERS/DIAPER SERVICES

EXERCISE PROGRAMS AND HEALTH SPA MEMBERSHIPS

EXPENSES INCURRED AS A SURROGATE MOTHER

FUNERAL EXPENSES

HAIR RESTORATION DRUGS/TRANSPLANTS/IMPLANTS

HEALTH CLUB DUES

HOUSEHOLD HELP

ILLEGAL OPERATIONS AND TREATMENTS

INSURANCE PREMIUMS

MATERNITY CLOTHES

MEDICINES OR DRUGS PURCHASED OUTSIDE THE UNITED STATES

NUTRITIONAL SUPPLEMENTS
You cannot include the cost of nutritional supplements, vitamins, herbal supplements, "natural medicines," etc. unless you obtain them with a physician's prescription and letter of medical necessity.

OVER-THE-COUNTER DRUGS AND MEDICATIONS
Over-the-counter drugs and medicine are not eligible unless the purchase was obtained by prescription. The documentation required for reimbursement of a prescribed OTC drug/medicine is subject to IRS guidelines and applicable laws.

PERSONAL TRAINER

PERSONAL USE ITEMS (e.g. toothbrush and toothpaste)

SAFETY GLASSES

TANNING BED (for a skin condition)

TATTOO REMOVAL

TEETH WHITENING OR BLEACHING

FLEX PLAN ENROLLMENT FORM J. J. STANIS and COMPANY, INC.

(Please print clearly)

PLAN YEAR BEGINNING 1/1/2016 ENDING 12/31/2016

Employee Information

Group Name: Herricks UFSD

Effective Date (mm/dd/yyyy): January 1, 2016 Hire Date (mm/dd/yyyy): December 31, 2016

Employee Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy)	SSN (XXX-XX-XXXX)
			/ /	- -

Home Address

City: State: Zip Code:

Daytime Telephone Number: ( ) E-Mail Address (optional)

Check one: ☐ New Enrollment ☐ New Plan Year Election (Re enrollment)

Benefit Elections

Please indicate the number of paychecks you receive per year:

(THESE CALCULATIONS MUST BE APPROVED BY YOUR PAYROLL DEPARTMENT)

	Annual Amount		No. of Paychecks		Paycheck Reductions
Health Care Expense	$	÷		=	
Dependent Care Expense	$	÷		=	
TOTAL AUTHORIZED SALARY REDUCTIONS (Pre-Tax Salary Reductions)	$				$

AUTHORIZATION: I understand that any salary reduction amounts not used by the end of the above plan year for eligible expenses incurred during the plan year will be forfeited by me in accordance with Section 125 of the Internal Revenue Code. I further understand that the reduction(s) specified above will be in effect for such plan year and can be revoked only if the election change is due and consistent with a change in my family status as defined in Section 125 and other applicable laws, rules and regulations, as well as allowed under my plan (e.g., family or employment change in status if allowed under my plan). I hereby authorize my employer to reduce my salary each pay period on a pre-tax basis by the amount of my benefit election(s) specified above. In the event that any reimbursement I may claim and receive under the Plan is later deemed unsubstantiated by the IRS, I hereby acknowledge and accept responsibility, and hold my employer and J. J. Stanis and Company, Inc. harmless, for any adverse tax consequences that may result. Furthermore, I have read and agree to the General Provisions indicated on subsequent page.

Employee Signature *Date*

Authorized Employer Representative (print name) *Date*

Authorized Employer Representative Signature *Date*

PLEASE SEE PAGE THAT BEGINS WITH GENERAL PROVISIONS

General Provisions **

- You cannot change your annual elections during the Plan Year unless you have a qualifying change in status event and your Plan provides for same Election changes must be requested within 30 days of the qualifying event. Qualifying change in status events include, but are not limited to:
  - a change in marital status (marriage, divorce, annulment, legal separation, or death of spouse),
  - a change in your number of dependents (birth adoption or death of a dependent), or
  - a change in employment status (you, your spouse, or a dependent's termination of employment or commencement of employment, strike, a commencement of or return from, unpaid leave of absense.
- The Employer/Plan Sponsor may reduce or cancel your salary reduction or otherwise modify this agreement if it is necessary to satisfy provisions of the Internal Revenue Code.
- Please refer to your Flex Plan documents, and other relevant materials provided to you, and relevant IRS publications for more information.

Flexible Spending Account Provisions (if applicable) **

- Any unused balances in your Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) at the end of the Plan Year or any applicable grace period will be forfeited (the "use it or lose it" rule).
- Expenses paid through your flexible spending accounts will no longer be eligible in computing deductions or tax credits on your income tax return.
- Eligible health care expenses are those that are deductible for federal income tax purposes as defined under IRC Section 213(d) and have not been reimbursed or paid by insurance or any other plan.
- Expenses reimbursed under the Dependent Care Reimbursement Account (DCRA) will reduce, dollar for dollar, the Dependent Care Tax Credit you may otherwise qualify for.
- The IRS generally considers the date of an expense to be the date service is rendered or received, not the date the expense is actually paid.
- You agree to indemnify and reimburse your employer and/or J. J. Stanis and Company, Inc. on demand for any liabilities that may occur from any reimbursement made for a non-qualified expense or for payment made in error.
- J. J. Stanis and Company, Inc., or your employer, cannot guarantee the tax treatment of Flexible Benefit Plan deposits.

** The information contained herein or in any of the documents/information provided by J.J. Stanis and Company, Inc. is subject to your Employer's Flex Plan Document(s) and applicable IRS rulings and publications, and applicable laws. Nothing contained herein or in any of the documents/information provided by J.J. Stanis and Company, Inc. shall be deemed or construed as legal or tax advice you are encouraged to seek the advice of your own counsel and consultants.

Request for Healthcare Reimbursement Expenses

Return completed form to:
J.J. Stanis & Company, Inc.
377 Oak St, Suite 406
Garden City, NY 11530
Fax Number 516-465-3920

Employer _____ Group Number _____

Employee Name _____ SS No. _____
Last First Middle

Home Address: _____
Number/Street City State Zip

Please check only if this is a new address. Daytime Telephone Number _____

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Check the box that applies. Supporting documentation as required by the IRS, applicable laws and/or your Plan must accompany this reimbursement request form.

- ☐ **I have group health (medical, dental, vision) insurance for this expense.** Attach a copy of the Explanation of Benefits (EOB) statement that you received from your insurance carrier showing how benefits were paid.
- ☐ **I do NOT have insurance coverage for this expense.** Submit an itemized statement showing the date of service, provider's name, and services Provided, and the amount of the charge.
- ☐ **I belong to an HMO.** Submit a paid receipt for your copayments. For expenses not covered, submit an itemized statement.
- ☐ **I am submitting expenses for orthodontia.** With your first request, submit a copy of the Truth in Lending Statement (contract) itemizing the treatment period, down payment and monthly payments, and the amount covered by insurance, if any. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment.

Date of Service	For the Benefit of (Name and Relationship)	Description of Service	Provider of Service	Requested Amount

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

Employee Signature: _____ Date: _____

If you have questions about a claim, or the FSA program, please call **(516) 465-3900** between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.

Request for Dependent Care Reimbursement Expenses

Return completed form to:
J.J. Stanis & Company, Inc.
377 Oak St, Suite 406
Garden City, NY 11530
Fax Number 516- 465 -3920

Employer _____ Group Number _____

Employee Name _____ _____ SS No. _____
Last First Middle

Home Address: _____ _____ _____ _____
Number/Street City State Zip

Please check only if this is a new address. Daytime Telephone Number _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

You may complete the reverse side of this form and obtain your dependent care provider's signature verifying charges, or you must submit a receipt or statement from the provider giving the from-to dates of service. IMPORTANT: You must provide the IRS with the name, address and Tax I.D. (or Soc. Sec. No.) of the dependent care provider on your federal income tax return. If you are unable to provide this information, the tax exclusion for the dependent care reimbursement account may be denied by the IRS.

Date of Service From mo/day/year to mo/day/year	For the Benefit of (Name and Relationship)	Provider of Service	Requested Amount
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

TOTAL $_____

Please provide the child care provider's tax identification number here: _____

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

Employee Signature: _____ _____ Date: _____

If you have questions about a claim, or the FSA program, please call (877) 470-3715 between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.

To access additional claim forms, please visit our website: www.jjstanisco.com

Employer _____ Group Number _____

Employee Name _____ SS No. _____
Last First Midd'e

Dependent Name _____

Home Address: _____
Number/Street City State Zip

VERIFICATION OF DEPENDENT CARE SERVICES/CHARGES

Provider of Service: _____

I certify that the charges listed on the reverse side for dependent care services have been incurred for the dates shown.

_____
(Signature of Provider)

_____
(Date)

VERIFICATION OF DEPENDENT CARE SERVICES/CHARGES

Provider of Service: _____

I certify that the charges listed on the reverse side for dependent care services have been incurred for the dates shown.

_____
(Signature of Provider)

_____

USING YOUR HEALTH FSA
FOR ORTHODONTIC EXPENSES

Information for Participants:

If you are considering using the Health Expense Flexible Spending Account (FSA) for orthodontic expenses, understanding how Flex determines your eligible expenses is very important. This document will assist you with planning for and claiming orthodontic expenses.

Please have your Orthodontist complete the enclosed **Orthodontics Worksheet** when filing for a claim. This form will serve two purposes. First, it can help you project your eligible expenses for the plan year. Second, if you decide to utilize the Health FSA for orthodontics, it can be used by the claims personnel to assist with expense verification.

You can also submit an Explanation of Benefits from your dental carrier along with the Dental claim form from the provider. These forms should have all of the same information as requested on the Orthodontic Worksheet.

Please note that if any of the needed information is not supplied, the claim may be pended until the necessary information is received. The following information is required from your service provider before any reimbursements can be processed:

1. Total amount charged for orthodontic treatment
2. Expected amount of insurance reimbursement
3. Total estimated treatment time
4. The date treatment began (the date of application of appliances)
5. Appliance fee charged and the monthly maintenance fee.

In order for an expense to be eligible through an FSA, the SERVICE MUST HAVE BEEN RENDERED, not necessarily paid for. **This means that you can only be reimbursed for services as they are rendered even if you paid for them in advance.**

Things to Remember:

1. The information on the orthodontic worksheet must come from an "independent third party". This means that the IRS will not just "take your word for it". The documentation must come from the Orthodontist or the insurance company if you have dental coverage.

2. Orthodontic treatment generally continues for several years. **When planning for those expenses, make sure to only include the value of the expenses that will be rendered during the plan year.**

J.J. STANIS AND COMPANY, INC.

Return by Fax to: (516) 465-3920

J.J. Stanis and Company, Inc.
377 Oak St, Suite 406 Garden City, NY 11530
Questions? (877) 470-3715 or (516) 465-3900

ORTHODONTIC WORKSHEET

Section I: Patient Information

Patient Name: _____ Date of Birth: _____
Responsible Party: _____ Diagnosis: _____

Section II: Financial Information

(1) The total cost of treatment is expected to be: $_____
(2) The Primary Insurance Carrier is expected to pay: $_____
(3) The Secondary Insurance Carrier is expected to pay: $_____
(4) "Out-of-Pocket" expenses to responsible party: $_____
(5) Date Treatment Began or is Expected to Begin: ____/____/____

Section III: Expenses

Amount Charged or Percentage of Total Treatment	Procedures:	Has this procedure been performed? If "YES", list Date of Service.
	for Pre-treatment (X-rays, molds, spacers)	YES NO
	for Application of the Appliances	YES NO
	for Ongoing Treatment	YES NO
	for Removal of Appliances	YES NO
	for Post-treatment (retainers, positioners, etc.)	YES NO
	for Other Expenses (please explain on separate sheet)	YES NO
	TOTAL (this should equal 100% or the amount listed as the Total Cost of Treatment)	

Section IV: Other Information

Estimated Treatment time is _____ months

We offer a _____ discount if all fees are paid in advance.

	Yes	No
Will there be additional charges if treatment time is longer than estimated?		
If the total fee is paid in advance and treatment must stop due to Extenuating circumstances (i.e.: transfer, disability, death) will a refund be made?	Yes	No

Section V: Service Provider Information and Signature

The information provided above may be used as a planning tool, and is not a contract for services. The above estimates are reasonable for client use in benefit planning and documentation. I understand that I may be asked for additional information and documentation as services are rendered.

Provider Name: _____ Phone Number: _____
Provider Address: _____ Fax Number: _____
_____ Contact Person: _____
_____ _____
Signature Date