# Personal Use Statement

FBMC
Premier Benefits Solutions

P.O. Box 1800, Tallahassee, FL 32302-1800

## Why would I need to submit a Personal Use Statement?

When you enrolled in your Employer's Medical Expense Flexible Spending Account (FSA) Plan, you agreed to the following:

- I will only use my FSA to pay for IRS-qualified expenses, permitted under my Employer's plan, incurred by me, my spouse and my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

FBMC, along with your Employer, has developed these instructions to assist you in complying with this agreement by explaining how and when to use a Personal Use Statement.

## What expenses are eligible?

Eligible expenses include amounts for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body, and are confined strictly to those incurred primarily for the prevention or alleviation of a physical or mental defect or illness. Please refer to your Employer's current plan year Flexible Benefits Plan Reference Guide for additional information on expenses eligible through your Employer's plan.

## How do I seek reimbursement?

In order for incurred expenses to be reimbursed from your Medical Expense FSA, you must follow these instructions. Only the cost of medical care and services permitted under both IRS Code § 213 and your Employer's Medical Expense FSA plan are reimbursable. If these expenses include those services, procedures, medicines or items that can be provided for both a medical purpose and a cosmetic, personal, living and/or family purpose, as well as those involving some capital expenditures, additional substantiation must be submitted with your claim.

## What is a capital expenditure?

A capital expenditure is an item that has a useful life that extends beyond the end of the taxable year, such as an elevator, bathtub railings, etc. A capital expenditure may be reimbursed if its primary purpose is:

- to provide medical care for you as a participant, your spouse or tax dependent for an existing medical condition and
- properly substantiated as medically necessary by showing that it would not be medically necessary "but for" an existing medical condition.

This Personal Use Statement, along with a Letter of Medical Need, may be required when you submit a request for reimbursement. Refer to *When do I need to submit a Personal Use Statement?*, information in your Employer's current plan year Flexible Benefits Plan Reference Guide and on your FSA Reimbursement Request Form for additional information. For more assistance or to obtain a sample form, visit FBMC's Web site at **www.myFBMC.com**, contact Fringe Benefits Management Company (FBMC) Customer Service at call 1-800-342-8017, 7 a.m. to 10 p.m., Monday through Friday.

**Note:** If improper reimbursement of ineligible Medical Expense FSA expenses has been made, the corrective procedures approved by the IRS and permitted under your Employer's Medical Expense FSA Plan will be followed.

## When do I need to submit a Personal Use Statement?

You must complete and submit a Personal Use Statement with your FSA Reimbursement Request and Letter of Medical Need if you are requesting reimbursement for a medically-necessary, special version of an item that is ordinarily used for cosmetic, personal, living and/or family purposes. Only the additional amount of expense over the cost of the item in its normal form is eligible for reimbursement.

For example, if a medical condition requires a salt-free diet, then only the **difference** between the cost of the normally-available food item and the salt-free version is eligible for reimbursement. The entire cost of the special food item is not eligible for reimbursement. You must show the calculations you used to determine the amount eligible for reimbursement in the space provided on your Personal Use Statement.

Refer to the information on this sheet to determine if additional documentation is required to reimburse your expenses. To obtain a sample form, visit FBMC's Web site at **www.myFBMC.com**, contact FBMC Customer Service at call 1-800-342-8017.

## Personal Use Statement Instructions:

Please **print** all requested information, except signatures, on the reverse of these instructions to ensure proper handling. At the top of the Personal Use Statement, you must include:

- the FSA participant's name
- the FSA participant's Social Security number
- the name of the FSA participant's employer
- the patient's name and
- the patient's relationship to the Medical Expense FSA participant.

Provide the information requested in the appropriate section:

- Print the name of the medically-necessary item for which you are requesting reimbursement. (Remember to include your completed Letter of Medical Need with your reimbursement request.)
- Indicate the cost of the **special version** of the item listed.
- Indicate the cost of the item listed in its **normal form**.
- Calculate the **difference** between the cost of the special version of the item listed and the cost of the item in its normal form. The amount of this calculation is the amount eligible for reimbursement.

If you have additional questions, or need to request a Letter of Medical Need, visit FBMC's Web site at **www.myFBMC.com**, contact FBMC Customer Service at call 1-800-342-8017.

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**PLEASE PRINT ALL REQUESTED INFORMATION, EXCEPT SIGNATURES, TO ENSURE PROPER HANDLING. SEE REVERSE FOR ADDITIONAL INSTRUCTIONS.**

**Participant Name:** _____ **Participant's Social Security Number:** _____

**Participant's Employer:** _____

**Patient Name:** _____ **Relationship to Participant:** _____

## Personal Use Statement

- I understand that I must submit, with my reimbursement request, a Letter of Medical Need that has been properly completed by the health care professional treating the above-named patient. (Information on how to obtain a blank Letter of Medical Need is on the other side of this document.) The Letter of Medical Need substantiates that I seek reimbursement for the cost of a medically-necessary, special version of:

  _____.
  Medically-necessary Item

- I understand that only the additional amount of expense over the cost of the item listed above in its normal form is eligible for reimbursement. (Refer to the reverse side of this sheet for more information.)
- The cost of the **special version** of the item listed above is: $_____.
- The cost of the item listed above in its **normal form** is: $_____.
- The **difference** between the cost of the special version of the item listed above and the cost of the above item in its normal form is: $_____.
  (This is the amount eligible for reimbursement.)

**Participant's Signature:** _____