

GROUP BENEFIT ADMINISTRATORS OF CONNECTICUT



FSA Capital Expenditure Form

Employer Name: _____

Employee Name:	First _____ MI _____	SS#	
Address :	City _____ State _____ Zip _____	Phone:	() _____

Please check if this is a new address

* Information below must be completed

CAPITAL EXPENSE	
This section must be completed if you are claiming a capital expense for yourself, your spouse or your tax-qualified dependent. It must accompany a Medical Necessity Form Letter. See the GBAC FSA Capital Expenditure Form Example for instructions on how to complete.	
CAPITAL EXPENSE WORKSHEET	
1. Enter the amount you paid for the home improvement:	\$ _____
2. Enter the value of your home immediately after your home improvement:	\$ _____
3. Enter the value of your home immediately before your home improvement:	\$ _____
4. Subtract line 3 from line 2. This is the increase in the value of your home due to the improvement:	\$ _____
✓ If line 4 is more than or equal to line 1, you have no medical expenses due to the home improvement; stop here. ✓ If line 4 is less than line 1, go to line 5.	
5. Subtract line 4 from line 1. These are your medical expenses due to the home improvement:	<u>\$ _____</u>
I certify that the above information is a true and accurate representation of expenses for special equipment installed in a home or home improvement whose main purpose is medical care for myself, my spouse or my tax-qualified dependent.	
Participant Signature	Date

KEEP THE ORIGINAL COPY FOR YOUR RECORDS

RE-SUBMIT A COPY WITH THIS CLAIM & ALL SUBSEQUENT CLAIMS FOR THIS CONDITION

FAX TO: 203.234.1139
OR MAIL TO:
GBAC
23 MAIDEN LANE
NORTH HAVEN, CT 06473

(01/2010)