TPA Systems Inc.
Letter of Medical Necessity (LOMN)

Overview

In general, individuals must use funds from a flexible spending account (FSA) or Health Reimbursement Arrangement (HRA) for medical care. Medical care is for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting a structure or function of the body {section 213(d) of the Internal Revenue Code}.

Deductions and reimbursements for medical care are limited to expenses paid primarily for the alleviation or prevention of a physical or mental defect or illness {section 1.213-1(e)(1)(ii) of the Income Tax Regulations}.

A taxpayer claiming a deduction or filing for reimbursement must establish that the expense is primarily for medical care. Among the objective factors indicating that an otherwise personal expense is for medical care are the taxpayer's motive or purpose, recommendation by a physician, linkage between the treatment and the illness, treatment effectiveness, and proximity in time to the onset or recurrence of a disease (Havey v. Commissioner, 12 T.C. 409, 1949). The taxpayer must also establish that the expenses would not have been incurred "but for" the disease or illness (Commissioner v. Jacobs, 62 T.C. 813, 818, 1974); (Altman v. Commissioner, 53 T.C. 487, 1969).

Accordingly, TPA Systems requires HRA or FSA plan participants who file for reimbursement of expenses that could be regarded as dual purpose or personal to provide this LOMN, executed by an attending physician, that substantiates the conditions for which the expenses are being claimed, and an attestation by the plan participant of same.

Attestation by Attending Physician (print name here)____

1. Diagnosed medical condition being treated: ____

2. Recommended treatment/item: ____

3. Duration of treatment (not to exceed one year): ____

I certify that this treatment and/or item: a) is medically necessary to treat the specific medical condition described above; b) is not recommended but for the condition specified; c) is not recommended for the general health of the plan participant, and d) is not for cosmetic purposes or to improve appearance.

____ ________________________________

physician signature physician signature date

Physician address: ____

Attestation by Plan Participant (print name here): ____

I hereby affirm the accuracy of the statements made herein by my physician, that the expenses I am claiming conform with the information contained within the "Overview" section of this form, and that the reimbursement of this item is not being duplicated under any other welfare plan.

I understand that I must provide a new LOMN to TPA Systems annually. I agree that this LOMN is valid for a specific time period as follows: a) if properly executed and dated in December, the effective period shall be the succeeding calendar year; b) if properly executed and dated in any month other than December, the effective period shall be the calendar year in which it is executed.

I also understand that there could be legal and tax consequences if the expenses claimed and supported by this LOMN are deemed ineligible by the Internal Revenue Service, including, but not limited to, imputing the amount claimed as income to the claimant.

_________________________________ _______________ _________________________________

signature of plan participant signature date name of employer