



FlexDirect



FSAHC-01



Health Care Flexible Spending Account Claim Reimbursement Form

How To Prepare Your Claim Form

Step 1 Complete all employee information. This form will be processed electronically. Print clearly and only in the spaces provided.

Step 2 Complete expense information. If the expense was incurred for an eligible dependent, indicate type of relationship in the box on the dependent name line. Use "C" for child, "S" for spouse or "O" for other.

Step 3 Sign and date the claim form and attach proof of expense. Bills, statements, or "Explanation of Benefits" (EOBS) from medical plan(s) are required proof of expense(s). Canceled checks are not sufficient evidence as proof of expense.

IMPORTANT! DO NOT combine multiple expenses on a single line. List each expense separately. Whether submitting single or multiple claims via fax, always send the claim form followed by its supporting documentation or receipts. Retain a copy for your records.

Employee Information

(PLEASE PRINT)

Please check this box if any of your information has changed

Change indicator box

Name Employer Name

Address Email Address (By providing your email address, you will receive electronic notifications)

City State Zip Daytime Phone #

Social Security Number

Social Security Number input area

Instructions: Please use blue or black ink and print like this



Number input area 0-9

Expense Information

Expense information table with columns for Start Date of Service, Amount, and provider details.

Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me or by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Additionally, these expenses are not being claimed as tax deductions under Section 213 of the IRS code. Bills, statements, or other proof of the expenses are attached.

SIGNATURE

DATE