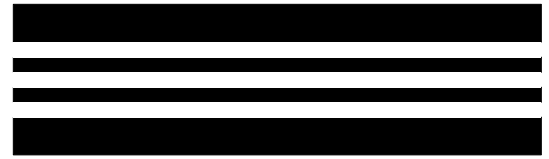
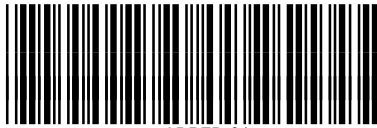




**FlexDirect**



## FlexDirect Expense Substantiation Form

### How To Prepare Your Substantiation Form

**USE THIS FORM ONLY IF YOUR FLEXDIRECT DEBIT CARD WAS USED TO PAY FOR THIS EXPENSE AND YOU RECEIVED A REQUEST FOR SUBSTANTIATION**

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

**Step 2** Complete transaction information. Indicate type of FSA or Commuter Benefit plan on the Plan Type line. Use "HC" for Health Care, "DC" for Dependent Care, "T" for Transit or "P" for Parking.

**Step 3** Sign and date the substantiation form and attach proof of expense. Bills, statements, or detailed receipts are required proof of expense(s). Canceled checks are not sufficient evidence as proof of expense.

"Explanation of Benefits" (EOBs) from medical plan(s) may be required as documentation for health care expenses.

**IMPORTANT!** Always send the substantiation form followed by its supporting documentation or receipts. Retain a copy for your records.

Social Security Number

\_\_\_\_\_

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



0 1 2 3 4 5 6 7 8 9

### Employee Information

(PLEASE PRINT)

Name \_\_\_\_\_ Employer Name \_\_\_\_\_

Address \_\_\_\_\_ Email Address \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

### Transaction Information

Transaction Number \_\_\_\_\_ Transaction Date \_\_\_\_\_

Merchant Name \_\_\_\_\_ Amount \_\_\_\_\_ Plan Type \_\_\_\_\_

**To Submit Your Receipts: Fax To: (678) 762-5900 Or Mail To: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853**

**Questions and Information: Call (800) 654-6695 or Visit [www.flexdirect.adp.com](http://www.flexdirect.adp.com)**

### 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 any other plan(s). I further certify that if the above expenses are not eligible I will remit payment in the amount of the ineligible expense to the plan. Additionally, these expenses are not being claimed as tax deductions under IRS code. Bills, statements or other proof of the expenses are attached.

Signature \_\_\_\_\_

Date \_\_\_\_\_