

## Reimbursement Claim Form for Health Flexible Spending Account

### A General Instructions

Use this form to claim reimbursement for eligible healthcare expenses; minimum amount required for processing is \$ \_\_\_\_\_.

You may submit any amount from \_\_\_\_\_ (date) through \_\_\_\_\_ (date). (Employer selects based on whether permitting grace period claims. There is no minimum amount required during these months.)

Your total reimbursement for the year cannot exceed the total amount of salary reduction you elect to contribute to your account. A Health Flexible Spending Account (FSA) remaining balance and any unreimbursed claims from a prior plan year cannot be carried over to the next plan year and will be forfeited.

### B Employee Information

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### C Claim Information

I hereby request reimbursement of the following healthcare expenses incurred during the plan year. The employer should include the following language if using the grace period option: (and its ensuing grace period) \_\_\_\_\_.

The employer should include the following language if using the grace period option:

For expenses incurred during the grace period:

- Please reimburse me from amounts contributed during the previous plan year.
- Please reimburse me from amounts contributed during the current plan year.

Photocopies of bills, receipts, or cancelled checks can be used for proof of incurred expenses. For expenses previously submitted under your or your spouse's medical or dental coverage or your spouse's Health FSA that were not reimbursed or only partially reimbursed, attach copies of the "Explanations of Benefits" you received. You are solely responsible for the validity of all claims.

Dates of Service	Patient (give full name of spouse or dependents if other than yourself)	Provider of Service	Item or Service for Reimbursement	Amount
				\$
				\$
				\$
				\$
			<b>TOTAL</b>	<b>\$</b>

I certify that the foregoing is true and correct and that I have not previously received, nor will receive, reimbursement for the items listed above from any other source. I understand that expenses reimbursed from my Health Flexible Spending Account cannot be claimed on my personal federal income tax form. I further certify that I have met all the requirements for reimbursement of eligible expenses as described in the current Health Flexible Spending Account materials provided by my employer.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer's Authorized Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_