Claim Form – Health or Limited Purpose FSA Reimbursement

☐ *Please check here if new mailing address* ☐ *Please check here if new email address*

Section 1: Employee Information

Employer Name (Please Print) _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

Section 2: Claim Information

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.
All information below must be completed.

Service Date (mm/dd/yyyy)	Service Date (mm/dd/yyyy)	Patient Name & Relationship	Provider Name & Address	Description of Service	Amount
					$
					$
					$
					$
					$
					$
				Total	$

Section 3: Signature

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature _____ Date ____/____/____
mm/dd/yy

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

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