

Flexible Spending Account Claim Form

A. ACCOUNT HOLDER INFORMATION - COMPLETE FOR ALL CLAIMS

EMPLOYER NAME (required to process claim):					
EMPLOYEE NAME	Last	First	Middle Initial	Is this a new address? <input type="checkbox"/> YES <input type="checkbox"/> NO (check one)	
MAILING ADDRESS	Street	City	State	Zip	
Social Security Number	E-Mail Address				

PLEASE READ THE DETAILED INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS FORM

B. HEALTH CARE / MEDICAL FSA

Check the box if this claim is for substantiation of a Benefit Card™ transaction

Item #	Patient's Full Name	Relationship To Employee	Soc. Sec. No.	Date of Birth	Date(s) of Service (example: 03/23/06 to 03/25/06)	Service Provider (Doctor Name, Pharmacy, etc.)	Description of Service (Prescription, Glasses, etc.)	Amount of Claim
H1								
H2								
H3								
H4								
H5								
H6								
Total Amount								

C. DEPENDENT CARE FSA

Check the box if this claim is for substantiation of a Benefit Card™ transaction

Item #	Patient's Full Name	Relationship To Employee	Soc. Sec. No.	Date of Birth	Date(s) of Service		Service Provider * (Name and Soc. Sec. No. or Tax-ID)	Nature of Service (Daycare, Camp, etc.)	Amount of Claim
					FROM	TO			
D1									
D2									
D3									
D4									
D5									
D6									
Total Amount									

* Is the Service Provider a relative? Yes No - If Yes, what is the relationship? _____

D. CERTIFICATION AND SIGNATURE

- I certify that this claim for reimbursement under the Health Care / Medical Flexible Spending Account represents expenses that have not been reimbursed (and I will not seek reimbursement) through my group health plan or any other health plan. I further clarify that the expenses claimed above were incurred for my medical care or for the medical care of my spouse or dependent child(ren). Medical care includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (but excluding cosmetic services). I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.
- I certify that the services I am claiming for reimbursement under the Dependent Care Flexible Spending Account are necessary to enable me and my spouse to work and that the information I have provided regarding these services is accurate.

	Employee Signature	Date
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Instructions on completing the claim form

Claims cannot be reimbursed without fully completing section A. of the claim form. Please make sure to enter the name of your employer, your full name, address and social security number. Sections B. and C. need to be completed when requesting reimbursement for these expenses. Number your EOBs and receipts to correspond with the "Item #" column in these sections.

Your claim request will be returned, unless all of your information is complete!

Please Note: Your E-mail address is optional. By entering your E-mail address you are agreeing to have information regarding your account and any additional documentation for specific claims automatically sent to your E-mail account.

Complete the following for each itemized expense incurred:

Patient's Full Name – you or your dependent

Relationship to Employee – self, spouse, child, etc.

Soc. Sec. No. – the individual's Social Security Number

Date of Birth – the individual's date of birth

Date(s) of Service – the date the expense was incurred, not the date you received a bill or when the bill was paid

Service Provider – the name of provider of service – for Dependent Care claims this also includes the Social Security Number or Tax Identification Number (TIN) of the provider

Description of Service/Nature of Service – an explanation on the type of service (e.g., office visit, prescription, daycare, camp, etc.)

Amount of Claim – the amount requested for reimbursement (e.g., co-pay amounts, deductibles, co-insurance, etc.)

For the Health Care / Medical FSA - Attach an **itemized bill or receipt** (which you should obtain from the provider of service) and the **corresponding Explanation of Benefits**, if applicable, from the carrier to this form. Canceled checks and "balance forward" bills are not acceptable forms of documentation. Cash register receipts may only be used for over-the-counter medicines and must identify the item purchased and the date. Reimbursement will be processed in accordance with the provisions of your Health Care / Medical FSA reimbursement plan and applicable law.

A. ACCOUNT HOLDER INFORMATION - COMPLETE FOR ALL CLAIMS									
EMPLOYER NAME (required to process claim): <u>My Company USA</u>									
EMPLOYEE NAME Last	First	Middle Initial	Is this a new address? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (check one)						
<u>Sample</u>	<u>Carrie</u>								
MAILING ADDRESS Street			City	State	Zip				
<u>10023 Oak Street</u>			<u>My Town</u>	<u>PA</u>	<u>12345-6789</u>				
Social Security Number			E-Mail Address						
<u>123-45-6789</u>			<u>csample@mycompany.com</u>						

PLEASE READ THE DETAILED INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS FORM

B. HEALTH CARE / MEDICAL FSA									
Check the box if this claim is for substantiation of a Benefit Card™ transaction									
Item #	Patient's Full Name	Relationship To Employee	Soc. Sec. No.	Date of Birth	Dates of Service (beginning to ending)	Service Provider (Name, Address, etc.)	Description of Service (Prescription, Office Visit, etc.)	Amount of Claim	
H1	Carrie Sample	Self	123-45-6789	1-23-72	3-17-06	Donald Smith DDS	Dental Exam	85.00	<input checked="" type="checkbox"/>
H2	Steve Sample	Spouse	891-23-4567	8-25-69	3-20-06 to 4-1-06	ABC Pharmacy	Prescriptions	20.00	<input type="checkbox"/>
H3	Kim Sample	Child	456-78-9123	4-16-02	3-25-06	Abbie Brown MD	Office Visit	15.00	<input type="checkbox"/>
H4									<input type="checkbox"/>
H5									<input type="checkbox"/>
								Total Amount	35.00

C. DEPENDENT CARE FSA									
Check the box if this claim is for substantiation of a Benefit Card™ transaction									
Item #	Patient's Full Name	Relationship To Employee	Soc. Sec. No.	Date of Birth	Dates of Service FROM TO	Service Provider (Name and Soc. Sec. No. w/ Tax-ID)	Nature of Service (Daycare, Camp, etc.)	Amount of Claim	
D1	Kim Sample	Child	456-78-9123	4-16-02	2/28/06 to 3/31/06	Playtime (23-12345)	Daycare	400.00	<input type="checkbox"/>
D2									<input type="checkbox"/>
D3									<input type="checkbox"/>
D4									<input type="checkbox"/>
D5									<input type="checkbox"/>
D6									<input type="checkbox"/>
								Total Amount	400.00

* Is the Service Provider a relative? Yes No - If Yes, what is the relationship?

D. CERTIFICATION AND SIGNATURE		
I certify that this claim for reimbursement under the Health Care / Medical Flexible Spending Account represents expenses that have not been reimbursed (and I will not seek reimbursement) through my group health plan or any other health plan. I further certify that the expenses claimed above were incurred for my medical care or for the medical care of my spouse or dependent children. Medical care includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (but excluding cosmetic services). I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.		
I certify that the services I am claiming for reimbursement under the Dependent Care Flexible Spending Account are necessary to enable me and my spouse to work and that the information I have provided regarding these services is accurate.		
Employee Signature	Date	
<u>Carrie B. Sample</u>	<u>4/2/2006</u>	

For the Dependent Care FSA - Attach a receipt or bill from the provider of the service to this form. This bill/receipt must state the name and address of the provider and his/her Tax Identification Number (TIN) or Social Security Number. You will be reimbursed following claims submission - per the specifications of your plan. If there is not enough money in your account to pay the entire amount of the claim that you submit, the claim will be paid up to the amount in your account. You will not need to resubmit this claim again. As additional amounts accumulate in your account, you will automatically be reimbursed up to the full amount of the claim.

If you are submitting receipts to substantiate a Benefit Card™ transaction – **DO NOT** include the claim amount in the Total Amount section.

Sign and date the claim form (in section D.) or your claim will be delayed! No claims can be processed without a signature.

Submit fully completed and signed claim form along with all required documentation to:

The Benefit Headquarters®
 Attn: Spending Account Department
 P.O. Box 9052
 Radnor, PA 19087-9052

Fax: (610) 889-9128
 Attn: Spending Account Dept.

Important FSA Account Information – Read Carefully

- Services for eligible expenses must be incurred within the Benefits Plan Year in order for you to receive reimbursement. You will only receive reimbursement for services incurred while a participant in the Flexible Spending Account.
- For a listing of eligible expenses visit www.irs.gov.
- If you are enrolled in a High Deductible Health Plan with a Health Savings Account (HSA), please refer to your plan documents for the specific listing of expenses that are eligible for reimbursement under your FSA.
- You will not receive paper statements showing your FSA balances. However you do have 24 hour access to the FSA website to obtain up-to-date account balance information and to view or print your statement of activity. Please visit www.bhqdirect.net and follow the link for your account information. If you do not have Internet access, please call The Benefit Headquarters® for further assistance.
- In 2005, Congress changed the definition of "dependent". As currently written, if you provide over half the support of an individual with a specified relationship (such as parent, siblings, stepparent, domestic partner, etc), the individual will not qualify as a dependent for FSA reimbursement if the person has gross income of \$3,200 or more during the year. For example, a parent whom you support may not qualify as a dependent and FSA claims for this individual can not be reimbursed from your account. Please consult with your tax adviser to see if a person qualifies as a dependent before submitting claims.
- Use It or Lose It! – You must incur expenses for the full amount in your FSA by the end of the Benefits Plan Year or the balance may be forfeited. Expenses incurred by the end of the Benefits Plan Year may be filed up to 90 days from the end of the Benefits Plan Year.
- Dependent Care FSA elections are subject to Discrimination Testing and your Plan Year election may be reduced as a result of this testing. You will be notified of any changes.