

Health Care FSA Claim Form

Employer Name:

This claim form is for reimbursement from your Flexible Spending Account for health care expenses only. You should attach documentation to this form which supports your claims for benefits.

Employee Name (print)

Social Security Number

Check here if new address

Home Address (Street, City, State, and Zip Code)

Email Address

Amount Requested

Date(s) of Service

Services Performed

Routine Physical

Well Baby Care

Rx Copays

Non-covered Eye Exam

Dental Charges

Medical Charges

Charges in excess of reasonable & customary allowance (attach proof)

Other (please describe)

Read Carefully

I certify the medical care expenses submitted for reimbursement meet the following requirements:

1. The medical care services were rendered to me or eligible members of my family during the period I was a participant in the Health Care Account.
2. The medical care expense are not eligible to be paid by the health care coverage provided through my employer or from other source, such as my spouse's employer's health plan.

I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical care expenses are reimbursed under the Health Spending Account, I will not claim them as expenses for purpose of the tax deduction against income tax for medical care. I understand that the charges for which I am submitting are eligible charges in accordance with IRS guidelines and IRS Publication 502. I also understand that I cannot submit any health insurance premiums for reimbursement from my Flexible Spending Account.

SIGNATURE _____

DATE _____

Claim Filing Instructions

- 1) You may submit a Claim Form only if you are a participant in the Health Care Spending Account.
- 2) You may submit a Claim Form at any time during the Plan Year and for a specified period after your employment terminates as stated in the Summary Plan Description.
- 3) Reimbursements can only be made for eligible expenses incurred during the coverage period in which your contributions are made.
- 4) All receipts and other supporting documents must be attached to this Claim Form. Submitting cancelled checks or credit card receipts will not be accepted as proof of payment.
- 5) Claims and supporting documents must be forwarded to:

Alliance Benefit Group -MidAtlantic, LLC
Attn: FSA Department
575 South Charles Street, Suite 202
Baltimore, Maryland 21201
Fax (410) 895-0951

- 6) Claims will be processed according to your company's pre-determined schedule.
- 7) The IRS rules stipulate that any money left in your account(s) after all reimbursements for the Plan Year have been processed cannot be carried forward or returned.
- 8) You cannot receive payment from any other source for expenses submitted for reimbursement, and you must certify that you are not eligible to bill any other source for the reimbursement expenses.
- 9) If you receive reimbursement for expenses, you cannot claim these expenses for income tax purposes.
- 10) For a service period that begins in one Plan Year and ends in the next Plan Year, you will need to submit two Claim Forms, one for each portion of the period of service that falls in each such plan year.

Please make a photocopy of the Claim Form and all receipts for your records.