

Flexible Spending Account Claim Form

Employer name

Employee name

Social security number

Employee address

SERVICE CODE

- C - Co-payment
- D - Dental
- M - Medical
- P - Prescription
- V - Vision
- O - Other (please specify)

Check here if this is a new address.

I hereby request reimbursement from the account(s) marked below:

Health Care Reimbursement Account					
Date of service	Person receiving service	Relationship to employee	Provider of service	SERVICE CODE	Amount to be reimbursed
SUBTOTAL =					

Dependent Care Reimbursement Account					
Date of service	Person receiving service	Relationship to employee	Provider of service	Tax ID # of provider	Amount to be reimbursed
SUBTOTAL =					

Please provide receipt or fill out the following information: **SUBTOTAL =**

Care provider name **TOTAL =**

Care provider address

Care provider signature Date

I certify that this information is correct to the best of my knowledge and that I am requesting reimbursement only for eligible expenses that have actually been incurred and that are not payable by any other insurance plan. I understand that any expenses for which I am reimbursed from these programs are not tax deductible on my federal income tax return. I further understand that it is my responsibility to keep receipts to verify these expenses.

X _____ X _____
Signature Date



Getting reimbursed from the Health Care Reimbursement Program or the Dependent Care Reimbursement Program

To request reimbursement:

1. Complete a Flexible Spending Account Claim Form. You may request reimbursement for health and dependent care expenses on the same form.
2. Attach copies of your itemized receipts or an Explanation of Benefits from the insurer for the expenses. **Important: You can not be reimbursed if receipts do not accompany the request.** Cancelled checks **do not** qualify as receipts.
3. Receipts for dependent care expenses must include a written statement from the provider stating that the dependent care expense has been incurred, the amount of the expense and the tax ID number of the day care provider. Your dependent care provider's signature must be on the statement.
4. Sign and date the form.
5. Mail to: **TaxSaver**
P.O. Box 4539
Iowa City, IA 52244-4539

Or fax to: **800 974 5190**

Important information:

- Remember, only incurred expenses are eligible for reimbursement—expenses for procedures performed or services received during the plan year.
- It is your responsibility to acquire and keep receipts and other supporting documents to prove that the expenses were incurred and paid.
- You will need to attain the provider's tax ID number for dependent care expenses.
- Be sure to check that claims submitted are for expenses eligible for reimbursement.
- Funds from your Health Care Reimbursement Account must be used only for health expenses. Funds from your Dependent Care Reimbursement Account must be used only for dependent care expenses. Credit from one account **may not** be used to pay a claims against the other.
- For dependent care expenses, you can only be reimbursed up to the amount accumulated in your dependent care account. Larger claims will **automatically** be paid to you in future months as additional funds are deposited in the account from your paychecks. You **do not** need to file a second claim form for the same expense.
- You won't need to wait until the funds are present in your health care account to be reimbursed for the entire amount of your health claim—up to the amount "budgeted" to accumulate by the end of the plan year.
- You have a grace period of 90 days to submit claims and receive approval for expenses incurred in the previous plan year. **Any money remaining in your account after that date will be forfeited due to IRS rules.**
- Other questions? Please call **888 829 7287** or fax **800 974 5190**.