# FLEXIBLE SPENDING ACCOUNT CLAIM FORM

**Medical and Dependent Care Reimbursement Accounts**

EMPLOYER NAME: ______________________

SOCIAL SECURITY: ______________________

EMPLOYEE NAME: ______________________

(LAST) (FIRST) (M.I)

EMPLOYEE ADDRESS: ______________________

______________________

(CITY) (STATE) (ZIP)

## HEALTH CARE EXPENSES

| Patient | Relationship | Date(s) of Service | Amount Requested |
|---|---|---|---|
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## OVER THE COUNTER EXPENSES (HEALTH CARE EXPENSES)

| Name of User | Date Purchased | Name of Drug | Used For | Amount Requested |
|---|---|---|---|---|
| | / / | | | |
| | / / | | | |
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## DEPENDENT CARE EXPENSES

| Dependent Information | | | Provider Information | | |
|---|---|---|---|---|---|
| Name/Age | Relationship | Date(s) of Service | Name | Address | Amount Requested |
| | | From / /<br>Thru / / | | | |
| | | From / /<br>Thru / / | | | |
| | | From / /<br>Thru / / | | | |

I request payment of the above expenses from my Health Care Account and/or Dependent Care Account for the attached health care and/or dependent care expenses paid or to be paid by me. I certify that these expenses are not eligible for reimbursement from any other source.
I will not use expenses reimbursed through my Health Care Spending Account as deductions when filing my individual income tax return.
I also will not use expenses reimbursed through my Dependent Care Spending Account as a tax credit when filing my individual income tax return.

Any detailed health information provided in this form will be kept confidential and will only be used for claim processing purposes.

______________________ ______________________

EMPLOYEE'S SIGNATURE DATE

***SUBMIT THIS CLAIM FORM ALONG WITH THE *CORRECT DOCUMENTATION TO:***
PO BOX 1744, GRAND RAPIDS, MI 49501 OR FAX TO 616-454-4338. CONTACT US AT 616-454-4000 OR 800-876-7475.

*See reverse side of this form for a list of the documentation we will need to reimburse you.

## GUIDELINES FOR SUBMITTING FSA CLAIMS

# MEDICAL FSA:

- Submit your bill to your medical, dental, or vision insurance carrier.
- When the Explanation of Benefits Statement (EOB) is received from your carrier, submit this, along with a completed FSA Claim Form, to SecureOne Benefits Administrators, Inc. for reimbursement.*
- For **over the counter drugs** send in a copy of the register receipt from the pharmacy or store along with a completed FSA Form. The register receipt must show the name of the drug and when it was purchased.
- Be sure the claim is received in our office 2 business days prior to the scheduled date for claims processing for your employer to insure that it will be included with that date's check run.
- *Keep in mind that claims must total a minimum of $20.00 before a check will be processed (unless your balance for the year is below this amount).*

*In most circumstances, the Explanation of Benefits Statement from your insurance carrier is considered valid proof; however, there may be some circumstances where we will need a copy of the itemized statement as well, showing what the expense is.

## Please Note:

If you have health coverage with SecureOne and you have qualified for and elected automatic reimbursement, copies of your EOBs will be forwarded to our FSA Department for reimbursement. As stated in your salary reduction agreement, you may not use automatic reimbursement if you have secondary coverage. In this case we would need the EOB from your secondary insurance carrier.

# DEPENDENT (CHILD) CARE FSA:

- Complete an FSA Claim Form.
- Submit a claim form along with valid proof of dependent care expenses (receipt) showing the dates of service, as well as the provider and the cost for the dependent care.
- Be sure the claim is received in our office 2 business days prior to the scheduled date for claims processing for your employer to insure that it will be included with that date's check run.

If you are uncertain if an expense is reimbursable under your Flexible Spending Account, please contact us at 616-454-4000 or 800-876-7475.