

Flexible Benefit Plan Claim Form

THIS SIGNED FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Group Name: _____ **Plan Year:** _____

Employee Name: _____ ID or SSN Number: _____

Home Address: _____
Number & Street City State Zip Code

Email address: _____

Please check if new address or email address

Daytime Phone Number: _____ Number of pages: _____

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses with the date of service incurred by me, my spouse, or my qualified dependent(s) during the applicable plan year. I certify that these expenses have not been reimbursed by any other source, nor will any reimbursement be sought from any other source. By signing and submitting a Dependent Care Reimbursement Request, I am certifying that expenses for which I request reimbursement satisfy all dependent care guidelines. I and my spouse, where applicable, are gainfully employed or a full-time student and not on leave. In accordance with the Flex Benefit Plan, I authorize my Flexible Spending Account(s) to be reduced by the amount requested.

Employee Signature: _____ Date: _____
Signature Required

Medical Care Expenses:

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier may then be submitted to Key Benefit Administrators - Flexpro as a qualifying receipt towards your FSA Plan. Medical care receipts must be from an independent third party and must include the Name of the Patient, Name of the Provider, Type and date of Service or Supply provided (Names of Prescriptions are required), and the Amount of the Service or Supply. Receipts for eligible over-the-counter (OTC) drugs or medicines must include the same information as listed above. If necessary please add additional pages.

EFFECTIVE JANUARY 1, 2011 *The cost of over-the-counter medicines may not be reimbursed with excludible income through a Health FSA, HRA, HSA, unless the medicine is prescribed by a Physician. Copy of prescription from Physician is required.*

NOTE: Eligible expenses may be restricted for employees in a Limited Medical Care FSA. Eligible OTC expenses are only eligible post-deductible. The minimum deductible for the HDHP must be satisfied. Additional substantiation requirement will apply.

Name of Patient or Dependent	Date(s) of Service	Name of Provider or Merchant	Type of Service or Supply	Medical Care Charge for each service/supply	Flex Card Purchase Substantiation
Total					

As requested, a letter of medical necessity is included. A letter of medical necessity is on file.

Dependent Care:

Dependent Day Care receipts must include the Name of the Provider, Dates of Service, Name of the Dependent(s), Fee for Service or you may have your Dependent Day Care Provider complete and sign below (Original Signature required).

Date(s) of Service: (to & from) _____ Fee for Service: _____

Dependent(s) Name: _____ Dependent Date of Birth: _____

Dependent Care Provider Name and Tax ID #: _____

Dependent Care Provider Signature: _____ Date: _____

Dependent Care expenses for the care of a qualifying individual that are for the purpose of enabling the employee and the spouse, when applicable, to be gainfully employed or attend school full-time are eligible. Dependent Care may not be reimbursed while on Leave of Absence (LOA). *Exception for short, temporary absences.* An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence. A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the caregiving arrangement requires the taxpayer to pay for care during the absence.

The following reimbursement request rules apply: Medical Care and Dependent Care expenses must be incurred within the appropriate Plan Year. See Plan Specific page for eligibility requirements. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. *Cancelled checks are not acceptable receipts. This form must be signed and submitted with applicable receipts.*

Key Benefit Administrators P.O. Box 1179 Ft. Mill, SC 29716-1179
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