



CITY OF KETTERING FSA/HRA CLAIM FORM

I will pick up my check —

BRING ID

(See instructions on back of form or page 2.)

EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY #	NAME OF EMPLOYER	
		CITY OF KETTERING	
PLEASE CHECK IF NEW ADDRESS <input type="checkbox"/>	DAYTIME PHONE # ()	YOUR EMAIL	
HOME ADDRESS	CITY	STATE	ZIP
DO YOU OR YOUR ELIGIBLE DEPENDENTS HAVE INSURANCE COVERAGE FOR ANY OF THE FOLLOWING:	PLEASE SIGN BELOW		
HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO	To the best of my knowledge and belief, my statements in this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this plan, an HSA, or any other benefit plan and will not be claimed as an income tax deduction, nor will I seek reimbursement from any other source. I authorize my FLEX account to be reduced by the amount requested.		
DENTAL? <input type="checkbox"/> YES <input type="checkbox"/> NO			
VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	X	Date	
Employee's Signature			

HEALTH CARE EXPENSES BEING CLAIMED (Medical, Vision, Dental)

Administrative Use Only

Date of Service	Name of Patient	Description of Service Provided	Amount		
TOTAL					

WORK RELATED DEPENDENT CARE EXPENSES BEING CLAIMED

Administrative Use Only

Date of Service	Name of Dependent	Age	Day Care Provider & Tax ID or SS#	Amount		
TOTAL						

Total Pages Sent _____

FlexBank Administrators, Inc
Hours: 9 A.M. – 5 P.M. EST M-F
Phone number: 937.299.5515 ~ Free: 888.677.8373
Fax Number: 937.299.7992 ~ Free: 888.677.9373
Claims@FlexBank.net

THIS IS YOUR COVER SHEET FOR FAXED CLAIMS

GENERAL FLEX WITHDRAWAL – IRS Rules for required documentation

- A signed Flexible Spending Account Claim Form **must** be submitted with each batch of requests for reimbursement.
- Complete the personal information in full as well as sign and date the form. **A signature is essential to process reimbursement.**
- Indicate the dollar amounts being requested for reimbursement from your Flexible Spending Account.
- The date of service for the item submitted must be within your company's plan year or it will be considered an ineligible expense. If there is no date of service on the invoice or receipt, it will be considered an ineligible expense.
- If completing the form for claims for more than one member of your family, please use the same Flexible Spending Account Claim Form if space allows.
- Reimbursement requests are processed on a daily basis. It will generally take one business day from the date of receipt plus mailing time.
- Expenses paid by your Flexible Spending Account cannot be claimed as an income tax deduction.

MEDICAL/VISION/DENTAL – IRS Rules for required documentation

- **Prescriptions** - For prescription drugs, submit a copy of the tag (showing the cost, medication name, date of service, and the patient name) attached to the prescription bag—we cannot reimburse from a cash register receipt.
- **Over-the-Counter Medicines** – Submit a copy of the itemized cash register receipt showing the date, the item and the amount. If FlexBank cannot identify the item from the cash register receipt, we require that you also submit the box top. Please note, stockpiling is not permitted – only “reasonable” quantities that may be used during the plan year are eligible.
- **Insured Expenses With a Percentage Payable By You** - Where you are responsible for a percentage of the expense or an amount applied to your deductible, before we can reimburse you, the expense has to be submitted to your insurance company. Your insurance company will then send you a summary of the settled claims showing what you were charged and how much you owe. The name of this report may differ from carrier to carrier – “Explanation of Benefits” (EOB) and “Health Statement” are common nomenclature. Submit a copy of this EOB along with a signed Claim Form.
- **Co-pays** - Submit copies of itemized bills from the provider that include preprinted provider information, the date of service, the treatment rendered, the patient's name and the co-pay amount.
- **Uninsured Expenses** - If the expenses are for services excluded from your medical/dental/vision plan coverage, attach a copy of the itemized bills. NOTE: Expenses applied toward your health insurance plan deductible are not considered excluded from your medical/dental/vision plan coverage. A copy of the "Explanation of Benefits" (EOB) indicating the expense applied toward the deductible is required for reimbursement.
- **For orthodontia**, if your company's plan limits reimbursement to a down payment with monthly installments, you will need to first submit a copy of the orthodontic agreement. You will then need to submit either a copy of the payment coupon or a statement showing what you owe (or paid) for that month.

NOTE: Cancelled checks, credit card receipts, or balance due statements are not acceptable.

WORK-RELATED DEPENDENT CARE – IRS Rules for required documentation

- Attach an invoice or receipt of payment from a daycare center or from an individual who provides the care.
- Receipts must include the provider's name, address, tax ID# or SS#, the dates of service and the amounts paid.
- The individual who provided the care cannot be your spouse or your child under age 19.
- Children are eligible up to their 13th birthday.
- For children of divorced/legally separated parents, only the Custodial Parent may use this benefit.

SUBMITTING YOUR CLAIM

- Mail, fax, or email this claim form and any necessary attachments to:

FlexBank Administrators, Inc.
1250 West Dorothy Lane, Suite 107, Dayton, OH 45409
www.FlexBank.net
Claims@FlexBank.net
Phone: 937.299.5515 ~ Toll Free: 888.677.8373
Claims Fax Number: 937.299.7992 ~ Toll Free: 888.677.9373