FLEXIBLE SPENDING ACCOUNT
REQUEST FOR REIMBURSEMENT

EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY #	NAME OF EMPLOYER
PLEASE CHECK IF NEW ADDRESS ☐	DAYTIME PHONE # ( )	YOUR EMAIL

HOME ADDRESS	CITY	STATE	ZIP

DO YOU OR YOUR ELIGIBLE DEPENDENTS HAVE INSURANCE COVERAGE FOR ANY OF THE FOLLOWING:

HEALTH? _____YES _____NO

DENTAL? _____YES _____NO

VISION? _____YES _____NO

PLEASE SIGN BELOW

To the best of my knowledge and belief, my statements in this Request for Reimbursement 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 or any other benefit plan and will not be claimed as an income tax deduction. I authorize my FLEX account to be reduced by the amount requested.

Employee's Signature ______________________ Date ____________

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

Date of Service	Name of Patient	Description of Service Provided	Amount	Administrative Use Only
		TOTAL		

WORK RELATED CHILD CARE EXPENSES BEING CLAIMED

Date of Service	Name of Dependents	Dependent Care Provider	Tax ID or SS#	Amount	Administrative Use Only
			TOTAL		

1250 West Dorothy Lane, Suite 107
Dayton, OH 45409
Phone: (937) 299-5515
www.FlexBank.net
Hours: 9 a.m. – 5 p.m. M – F

Total Pages Sent ______________

Claims Fax Number: (937) 299-7992

THIS IS YOUR COVER SHEET FOR FAXED CLAIMS

GENERAL FLEX WITHDRAWAL INSTRUCTIONS

- A 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 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 day plus mailing time. However, FlexBank is not subject to this time frame.
- Expenses paid by your Flexible Spending Account cannot be claimed as an income tax deduction.

MEDICAL/VISION/DENTAL INSTRUCTIONS

- **Insured With A Co-Pay -** For prescription drugs, submit a copy of the tag (showing the cost, medication, date of service, and the patient name) attached to the prescription bag. For doctor office visits or other professional providers, submit a copy of the doctor's receipt showing the date of service, the patient's name, the provider's information, the treatment rendered, and the amount of the co-pay.
- **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 known as an "Explanation of Benefits" (EOB). Submit a copy of this EOB along with a signed Request for Reimbursement.
- **Insured Expenses With An HMO -** Send us evidence of co-pays where applicable. For all other services, submit copies of itemized bills from the provider that include the date of service, the treatment rendered, the patient's name and the amount paid by the HMO. You will generally receive this information from your provider when billed.
- **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 put towards your plan deductible are not considered excluded from your medical/dental/vision plan coverage. A copy of the "Explanation of Benefits" indicating the expenses that were put toward the deductible is needed.

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

WORK-RELATED CHILD CARE INSTRUCTIONS

- 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#, the dates of service and the amounts paid.
- The individual who provided the care cannot be your spouse, or child under age 19.
- Expenses claimed cannot exceed the lesser of you or your spouse's income.

SUBMITTING YOUR CLAIM

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

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Dayton, OH 45409
Phone: (937) 299-5515
Claims Fax Number (937) 299-7992