HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN
Claim Form

Company: _____ Employee Name: _____

This claim form is to be used only to request reimbursement from your Health Flexible Spending Account for health care expenses. When requesting reimbursement, the actual bill that you received, receipt of payment and/or other evidence that you have incurred the expense must be submitted with this claim form.

IN ALL CASES, YOU MUST SIGN THE BOTTOM OF THIS FORM

Date Expense Incurred	Name of Service Provider	Expense Description	Relation to Person for Whom Expense Incurred (i.e. self, son, daughter, spouse)	Amount
			Total	

When done, attach all necessary receipts and **mail, e-mail or efax** to:

NOTE: When submitting claims for medical reimbursement, all receipts/invoices/statement must indicate the original date of service, the provider's name and address, and a brief description of services provided. Credit card receipts and canceled checks by themselves are not acceptable forms of claim substantiation.

Please note that if you participate in a Health Savings Account, you will only be eligible for reimbursement of dental and vision expenses or medical expenses after the minimum deductible has been met.

I understand that if I am requesting reimbursement from my reimbursement account(s) for the expenses itemized above, by submitting this form I certify that the expenses for which reimbursement is requested under the reimbursement account(s) were for services received either by myself or my eligible dependents(s) , that I or my eligible dependent(s) have received the services described on the dates indicated, and these are my out-of-pocket expenses that qualify as valid expenses under the plan(s) and the Internal Revenue Code, that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Flexible Spending Account Plan. I also certify that any medically related expenses itemized above are to diagnose, alleviate or prevent a medical condition and not merely beneficial to general health. If this claim is for medical expenses: I understand that if I, my spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a Limited Purpose or Post Deductible Health Flexible Spending Account (Health FSA) or a Limited Purpose, Post Deductible, Suspended or Retirement Health Reimbursement Arrangement (HRA).

I further understand that reimbursed expenses cannot be claimed as credits or deduction on my personal tax return. I understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan(s), I may be liable for payment for all related taxes including federal, state or city income tax on amounts paid from the plan(s) which relate to such expense. This certification also applies to any Flex Debit Card payments for which receipts are included for items listed above.

_____ _____

Employee Signature Date

Northeast Benefits Management, LLC
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Scan and email: info@nbmus.com
Fax: (802) 304-1009 (Burlington exchange)

NBM
Employee Benefits Simplified