

Member Identification Number: (Employer assigned number or W ID)

Reimbursement Account Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
Fax: (855) 703-5305
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To avoid claim payment delay, you must sign, date and complete this form. You must also include supporting documentation.

WAIT! Did you know that you can file a claim online? Log in to www.HealthHub.com and select File a Claim under Quick Links. You can also find instructions online for completing this form.

Member Full Name:

(Last Name, First, MI)

Member Addres (Street, City, State, Zi	p Code)						
Note: If you have ar	n address change, pl	ease notify your emp	loyer. For security pur	poses, we can only accept	an address change	from you	employer.
Employer Name	:						
		Health Care I	Expenses (For yo	ou, your spouse and yo	our dependents)		
Coordination of B other than your prin				under another plan? Thi e EOB for each date of s		lical, den] No	tal, prescription or vision plan
				up automatic reimbursem r need to send this form a			le a copy of your orthodontia
Patient Name		Type of Service (deductible, dental, medical, orthodontia, OTC, RX, vision)		From Date of Service (not payment date) MM/DD/YYYY	To/Thru Date of Service (not payment date) MM/DD/YYYY		Amount Requested
							\$
							\$
							\$
							\$
		nother form. You can get claim forms at www.Heal Forms. Attach the appropriate documentation for each			Total		\$
Dependent				r completes and signs be h dependent must be liste			ude an itemized statement.
Exact Dates of Service			Amount Requested (Required) Qualifying Person's First and Last Name (Please Print)			Qualifying person is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12.**Please check, if yes.	
From To MM/DD/YYYY		Requested			Age On Service Date (Required)		
		\$					□Yes
		\$					□Yes
		\$					□Yes
		\$					□Yes
	Total	\$	**You	do not need to submit	evidence of diagno	osed me	dical condition.
Caregiver Information/Certification: My signature certifies that I have provided the services for these expenses for(Qualifying Person's First Name) Name (Must be printed)				Caregiver Information/Certification: My signature certifies that I have provided the services for these expenses for(Qualifying Person's First Name). Note: This is for a second caregiver, if you have more than one.			
Relative: □Yes □No				Name (Must be printed)			
Provider Signatur	re		Relative: □Yes □No				
				Provider Signature			

For Health Care FSA: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

For Dependent Care FSA: I certify that I have incurred the Dependent Care expenses for me and, if married, my spouse to work. These expenses are for my Qualifying Person. These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. These are regardless of when I am billed or charged for, or pay for the service. I acknowledge that I will have to report the caregiver's name, address and Tax Identification Number on Form 2441.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed material for the FSA or Limited FSA plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Employee Signature	Date
**If you are mailing your claim, please keep a copy of this claim form and supporting	nd documentation. We will not return these documents ** REV 08/2012