How to file a claim:

1. Complete top half of claim form.

2. Be sure to sign and date claim form.

3. Provide the name of a person we can speak with on your behalf (optional).

4. List Health Care expenses and attach the following documentation:

Medical & Dental – An Explanation of Benefits (EOB) or Health Statement from your insurance company; or an itemized statement from the provider.

As a reminder, insurance must pay first before you may be reimbursed from your health FSA.

Co-pays – Itemized bill from the provider with preprinted provider information, date of service, patient's name and co-pay amount.

Prescriptions - Rx tag or computer generated report from the pharmacist.

Over-the-Counter (OTC) medicines - A doctor's prescription (required), and an itemized cash register receipt showing the date, item and amount. (Stockpiling not permitted).

Orthodontia – A copy of the orthodontic agreement for our files. A copy of the payment coupon or a statement showing what you owe (or paid) for that month.

Unacceptable Receipts:
- charge card receipts
- balance due bills
- cancelled checks
- predetermination

5. List Work Related Dependent Care expenses and attach the following documentation:
An itemized statement from your provider with provider's name, address, tax ID# or SS#, dates of service and amounts paid.

???Questions???
Call us at 888.677.8373

Access your account information 24 hours a day, 7 days a week on flexbank.net.

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

☐ I will pick up my check - **BRING ID**

EMPLOYEE NAME	LAST 4 DIGITS OF EMPLOYEE SOCIAL SECURITY #	EMPLOYER NAME
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

Total # of pages included with this claim _____

PLEASE SIGN BELOW

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 account to be reduced by the amount requested.

Furthermore, the following person has authorization to speak with FlexBank on my behalf regarding the information contained in this claim:

Name_____

Employee Signature (required) **X**_____ **Date**_____

HEALTH CARE EXPENSES (Medical, Vision, Dental, Hearing)

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

WORK- RELATED DEPENDENT CARE EXPENSES

For eligible children up to age 13. School tuition is not an eligible expense. You and your spouse (if married) must both be working or be a full-time student to be eligible to participate.

Dates of Service From and To	Name of Dependent	Age	Day Care Provider & Tax ID or SS#	Amount
			TOTAL	

How to submit claims

- ✓ **via Mail: FlexBank, 1250 W. Dorothy Lane, Suite 107, Dayton OH 45409**
- ✓ **via Fax: 937.299.7992 or 888.677.9373**
- ✓ **via Email: Claims@FlexBank.net**
- ✓ **via Mobile: http://www.flexbank.net/m/**