

How to Receive Reimbursement from your Flexible Spending Account(s)

To receive your reimbursement...

1. After you have incurred an eligible expense during the plan year, complete a Reimbursement Form. Please note: Health care expenses must be processed first by your primary and secondary (if applicable) health plans.
2. Include the appropriate documentation along with a signed reimbursement form:
Health Care expenses: Send the Explanation of Benefits (EOB) from your insurance company (if you have partial coverage for the expense) or an itemized bill (if you do not). The EOB or bill must contain the actual date of service, the name and address of the provider, a description of the services and the amount charged.
Dependent Care expenses: Submit a Reimbursement Form or receipt containing your provider's signature, address, SSN or Tax ID#, the date of service, and the amount paid.
3. **Fax this entire sheet, complete and signed, along with the appropriate documentation to 1-877-488-6454 (Fax).**
 If you prefer, mail your completed and signed reimbursement form with the documentation attached to:
 FlexServ, P.O. Box 534134, St. Petersburg, FL 33747-4134.
 To expedite processing and allow scanning of reimbursements, loose receipts should either be legibly copied onto 8 1/2 x 11 paper or affixed with tape to a letter size sheet.
4. Requests for reimbursement received via FAX will be processed the latter of two business days after receipt of the claim or prior to your next scheduled claim reimbursement date. Claims received via mail may require one additional day for processing.
5. Health Care expenses: We will reimburse up to the amount you elected for the year minus any previous reimbursements.

Dependent Care expenses: We will reimburse up to the amount you have deposited in your account to date (through payroll deductions) minus any previous reimbursements.

6. Whenever you have a question about the status of a claim or your account balance, call **1-877-799-8820**.
7. Follow this process throughout the plan year whenever you have an eligible expense. Be sure to "use up" your entire election... if you don't, you will lose the dollars you have left over (according to IRS regulations).

Reimbursement Reminders

- ▼ Only eligible expenses incurred during your FSA plan year and while you are a participant are eligible for reimbursement.
- ▼ An expense is incurred when the service is provided – not when you are billed or pay for the service.
- ▼ Due to the nature of orthodontia and prenatal billing, prepaid expenses for the plan year can be reimbursed before the service is completed.
- ▼ Any unpaid Dependent Care amounts (due to expenses exceeding the amount in your account at the time of the claim) will be paid out automatically as money accumulates in your account. You do not need to resubmit the claim.
- ▼ You will also receive an account summary with each reimbursement in addition to a quarterly account statement.
- ▼ Notify your benefits representative within 30 days if you have a mid year election change and wish to make a corresponding change to your FSA election.
- ▼ You will have a grace period (listed on your FSA Highlights) after the end of the plan year to submit your claims and documentation for expenses incurred during your plan year.

FlexLine

**Around the Clock Service
for FSA Participants
1-877-799-8820**

Once you are a participant, you have direct telephone access to your health care and/or dependent care account information 24 hours a day. When you call, you can choose to quickly access your account information through the automated voice response system. The information that FlexLine provides will be current as of the close of the previous business day. If you prefer to speak to a "live" person, you can talk to a customer service representative during business hours.

FlexServSM
A Ceridian Service

**Health Care or Dependent Care
Flexible Spending Account**

Please complete ALL the applicable spaces.

- You may attach multiple HEALTH CARE receipts to this reimbursement form.
- This completed form serves as your dependent care receipt when signed by your Provider below.

Employee Name		Last	First	Middle Init.	Social Security Number	
Home Address	Number/Street	Apt #	City	State	Zip	Area Code/Telephone #
Company Name			Division/Location		Client Code	
<input type="checkbox"/> Please check if this is a new address.						
Total Health Care Expense(s) \$		Total Dependent Care Expense(s) \$		Provider's Signature		SSN or Tax I. D. #
		Provider's Address		Date(s) of Service From: To:		

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 for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee's Signature _____ Date _____

For faster service, fax this entire sheet, complete and signed, along with the appropriate documentation to 1-877-488-6454 (Fax).