SECTION 125 – FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT CLAIM FORM

Return completed form and receipts to:
PO Box 1587 • Pekin IL 61555-1587
www.groupplansolutions.com
Phone: 888-301-0747 • Fax: 855-545-7165
Email: flexspendhelp@groupplansolutions.com

Please select one:

❒ Substantiation (proof of purchase) for a debit card transaction

❒ New claim for which I expect a reimbursement check or direct deposit

EMPLOYEE INFORMATION

Employer Name: ______________________________

Employee Name: ______________________________ Member Number (SSN): ______________

Phone: ______________ Email: ______________________________

Employee Address: ______________________ City: ______________ State: _____ Zip: ________

EXPENSES TO BE REIMBURSED

NAME OF PATIENT & DESCRIPTION OF EXPENSES	DATE INCURRED	AMOUNT ELIGIBLE FOR PAYMENT UNDER THIS PLAN* (YOUR OUT OF POCKET COST)
		$
		$
		$
		$
	Total	$

*Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, worker's compensation, or any other policy of health insurance. Please keep a copy of this information for your records.

INSTRUCTIONS

Attach a copy of itemized bills supporting each listed item or expense. If you have medical or dental insurance coverage with another insurance company, you must submit a copy of the explanation of benefits for reimbursement. For drug expense reimbursement, you must submit a copy of the itemized drug receipt. Canceled checks and cash register receipts are typically not considered sufficient documentation. Reimbursement is made for expense incurred during the year, not for payments made on balance due amounts.

EMPLOYEE STATEMENT

I hereby confirm that the requested reimbursements are not payable through other sources, are accurate and all services have been performed. I confirm the expenses are for myself or a FSA eligible dependent. I confirm that I have not previously submitted this expense for reimbursement under this plan. I understand that if I am reimbursed for an expense that is determined to be ineligible, the amount of the expense will be considered taxable income to me, and I may also be subject to interest and penalties by the IRS and will be responsible for reimbursing the plan up to the amount of error.

Signature of Employee	Date

PLEASE KEEP A COPY FOR YOUR RECORDS AS RECEIPTS CANNOT BE RETURNED