Flexible Spending Account Reimbursement Request Form

FAX: (603) 647-4668 (Max of 15 pages)
Address: PO Box 1300, Manchester, NH 03105-1300
E-Mail: info@benstrat.com

Employee Name: (First, Last)	**Last 4 digits of SSN:**
Primary Phone:	**Employer:**
E-mail:	

E-mail is required to receive important account notifications.

Fill out form completely, including signature, and fax or mail to Benefit Strategies at the address listed above. Incomplete and unsigned claims will be returned. Please limit the number of pages faxed to a maximum of 15 pages. Reimbursement requests should be for a minimum of $25 (unless using remaining account balance). Notifications will be sent via e-mail for claim confirmation, payment notification and denial letters. Payments will be sent to address on record. Claims will be applied to the earliest eligible plan year.

Health Care Reimbursement Expenses

Amount to be Reimbursed	Service Date	Description of product or service:	Person receiving product/service:
$			
$			
$			
$			

$ ___________________ **TOTAL Health Care Reimbursement Expenses Requested**

Read Carefully: The undersigned participant in the plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Spending Account with respect to such expenses and that the expenses have not and will not be reimbursed under any other plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes, including federal, state, or city income tax on amounts paid from the Plan with relation to such expense.

EMPLOYEE'S SIGNATURE: (REQUIRED)		**DATE:**	

Did you know that you can…

- File your claim online and upload the receipt
- Sign-up for direct deposit online
- Update your account information online
- Visit www.benstrat.com

Health Care Reimbursement Expenses Filing Instructions

Who is eligible?

· An employee who is enrolled in the plan, and their legal spouse or tax dependent .

Examples of qualifying expenses

Medical, dental, vision, prescriptions and hearing expenses not covered by your health insurance.

Documentation must show

A. The date the expense was incurred (not the date paid).
B. The name of provider of services.
C. A description of the service and/or expense.
D. The amount of the expense for which you are responsible.

Be sure to attach a copy of the itemized receipt(s), or if you have insurance, please send the Explanation of Benefits Statement. Keep original receipts for your tax records.

Please Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.

If you have any additional questions regarding your plan please contact us by phone at (603) 647-4666 or (888) 401-FLEX (3539).
Visit us online at www.benstrat.com