Flexible Spending Account (FSA)
Claim Reimbursement Request Form

FCE BENEFITS

COMPANY INFORMATION (PLEASE PRINT)

Company Name

Division (if applicable)

PARTICIPANT INFORMATION (PLEASE PRINT)

Last Name		Primary Phone ( ) -
First Name		Secondary Phone ( ) -
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy) / /	Email Address (For Account Notifications)
Street Address (Check if New Address)		
City	State	Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /
		/ /
		/ /

REIMBURSEMENT REQUEST (PLEASE PRINT)

Please indicate your qualifying expenses below. **DO NOT include expenses reimbursed by any other source**.

HEALTHCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must include dates of service, description of service and the expense amount. Canceled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

DATE RANGE OF SERVICES From / / through / /

DESCRIPTION (Please list a brief description below of services – e.g. Rx, copay, contact solution, etc...)

TOTAL Healthcare Reimbursement Request

$ _____

(REQUIRED)

IMPORTANT: If this is a limited healthcare Flexible Spending Account - Submit claims only for dental and/or vision expenses

DEPENDENT DAYCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

The following information is REQUIRED: Business name; dates of service and the expense amount; either a receipt/bill OR your provider's signature below. NOTE: Canceled checks are acceptable for daycare expenses only; credit card statements/receipts are NOT sufficient proof of your claim.

DATE RANGE OF SERVICES From / / through / /

PROVIDER'S TAX ID or SSN

PROVIDER'S BUSINESS or NAME

TOTAL Dependent Daycare Reimbursement Request

$ _____

(REQUIRED)

Dependent Daycare Provider's Signature:

Date / /

CLAIM CERTIFICATION

I certify these expenses for which reimbursement is requested on my Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return.

Participant Signature (Required)

Date / /

SEND THIS FORM WITH A COPY OF YOUR RECEIPTS TO FCE Benefit Administrators (DO NOT SEND ORGINAL RECEIPTS)

Please submit this form with your required documentation to FCE by one of the three methods listed to the right.

Fax: 210-610-5139 ***(Please DO NOT include a Fax Cover Page)***
Mail: 4615 Walzem Road Suite 300 San Antonio TX 78218
Email: FSA@fcebenefit.com
Secure Upload:

Flexible Spending Account
Claim Reimbursement Instructions

1. **Complete all company and employee information** on the front page (please print/type). NOTE: Please include your e-mail address to receive an automatic e-mail notification whenever a claim is entered into our system and when a reimbursement is approved for you to receive payment

2. **Attach supporting documentation.** A copy of a receipt or EOB must accompany this request for each claim submitted for reimbursement. ***Do not highlight any part of your receipt.*** Be sure to keep your original receipts, bills, etc. for your records. All receipts are destroyed daily. Each claim request must include the following information to be eligible for reimbursement:

   Original date of service (not the date of payment)
   Description of service performed (refer to list of eligible expenses to identify valid services)
   Provider's name and address (If submitting receipts for dependent daycare expenses)
   Amount charged to you (do not include amounts reimbursed by another source)

3. **Healthcare – Flexible Spending Account Reimbursement Request:** Complete all required information ***(ie: Total Reimbursement Request Amount)*** and attach proof of expense as described above. C***anceled checks are NOT acceptable as proof of payment. Limited healthcare Flexible Spending Accounts may only reimburse claims for dental and/or vision expenses***

4. **Dependent Daycare – Flexible Spending Account Reimbursement Request:** Complete all required information ***(ie: Total Reimbursement Request Amount)*** and attach proof of expense as described above. ***Note: Canceled checks are acceptable as proof of payment***

5. **You MUST sign and date** the '***CLAIM CERTIFICATION'*** section on the front of this page

6. **Fax, Mail or Email** this form and supporting documentation directly to FCE:

   Fax: 210-610-5139 **(*Please DO NOT include a Fax Cover Page*)**
   Mail: 4615 Walzem Road Suite 300 San Antonio TX 78218
   Email: FSA@fcebenefit.com
   Secure Upload:

7. If you have questions please contact us:

   Call Customer Service: 800-298-7269
   Email your questions: FSA@fcebenefit.com

8. **Important** Reminders**:**

   All requests are saved as electronic images. To ensure your claim is processed as soon as possible, and avoid delays:

   Do NOT use a fax cover page when faxing
   Do NOT highlight any part of your receipts, bills, etc.
   Only send copies of receipts, bills, etc. (Keep your originals)
   Multiple receipts should be totaled on one claim form
   Payments are issued after receipt and processing, subject to claim approval
   Claims may not be paid across accounts (healthcare from dependent daycare and vice versa)
   Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year
   Dependent daycare claims may only be reimbursed for the amount you have in your account at the time of your claim. If your claim is for more than the balance in your account, the rest of your claim will be paid when more money is added
   You may only be reimbursed for eligible expenses incurred during the current plan year
   Note: Orthodontia expenses are reimbursed as designated by the provider
   Payment will be made directly to you. Payments cannot be made to a provider or another person

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Any person who **knowingly presents a false or fraudulent claim** for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.

- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.