Flexible Spending Account (FSA)

Healthcare / Medical Expense Claim Form

(Use this form to request reimbursement from your Flexible Spending Account.)

Employee Name: _____
(Please print.)

Employer: _____

Last 4 digits of Social Security No.: XXX – XX – _____

The undersigned Participant in the Plan requests reimbursement in the amounts shown below. Federal law stipulates that written statements (such as itemized receipts, bills, or invoices from the service provider) must accompany all claims, as well as proof that the claim is not being reimbursed by insurance. You will not be entitled to claim these expenses as a tax deduction.

*The attached receipt(s) must show the **date of service and type of service** for the expense. Canceled checks, credit card slips, or statements showing only a balance due on your account are not acceptable.*

Medical Expenses

Date Incurred	Name of Service Provider	Description of Expense	Person for Whom Expense Incurred	Net Amount

If needed, use our Supplemental Expenses Worksheet found on our web site (or a blank sheet of paper) to list extra items, and then enter the total on the specified line below.

Total from supplemental worksheet _____

Grand Total _____

Please Read Carefully: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Section 125 Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. 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 the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____

Employee's Signature (*Required*) **Date**

Submit your claim form and receipts:

Mail: Flex Claims Group, Savers Administrative Services, 615 Saint George Square Court · Suite 300 · Winston-Salem, NC 27103-1368
Fax: 336-759-3999
E-mail: flex@saversadmin.com – scan and send claim form and receipts as attachments

Please do not complete a claim form if expenses were paid for with your Flex Account benefit card.

If you need a Dependent Care / Daycare Claim Form, or our Additional Expenses Worksheet, you may download them from our Web site, www.saversadmin.com

Always remember to keep a copy of the completed claim form and supporting documents for your records.

Asure

Savers Admin · 615 Saint George Square Court · Suite 300 · Winston-Salem, NC 27103-1368
336.759.3888 Local · 800.949.0311 Toll-Free · 336.759.3999 Fax
www.saversadmin.com/FSALogin · flex@saversadmin.com

Flexible Spending Account (FSA)

Supplemental Worksheet
for listing additional Health / Medical Expenses

Employee Name: _____
(Please print.)

Employer: _____

- *This worksheet may be used to list additional items when there is not enough room to list them on the Claim Form.*
- ***This worksheet must be submitted with a signed Claim Form.***

Medical Expenses

Date Incurred	Name of Service Provider	Description of Expense	Person for Whom Expense Incurred	Net Amount

Total the items on this Worksheet,
and then enter the total on the Claim Form where indicated. **Worksheet Total** _____

Please do not complete a claim form if expenses were paid for with your Flex Account benefit card.

Asure

Savers Admin · 615 Saint George Square Court · Suite 300 · Winston-Salem, NC 27103-1368
336.759.3888 Local · 800.949.0311 Toll-Free · 336.759.3999 Fax
www.saversadmin.com/FSALogin · flex@saversadmin.com

Flexible Spending Account

Filing Instructions for Health / Medical Expenses

Please do not complete a claim form
if expenses were paid for with your Flex Account benefit card.

When filing your claim, you must attach copies of the receipts. **The receipt must show the date of service and type of service for the expense.** Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

Always remember to keep a copy of the completed claim form and supporting documents for your records.

If you choose to **mail** your claim with receipts, the address is Flex Claims Group, Savers Administrative Services, 615 Saint George Square Court, Suite 300, Winston-Salem, NC 27103-1368.

If you choose to **fax** your claim with receipts, the fax number is 336-759-3999. After you fax a claim and receipts, please **do not** follow-up with a hard copy in the mail.

To **verify** that your claim has been received, please go to the Web site described below. When your claim is approved, it will appear within three business days on the Web site under the “Accounts” section.

You may check your **account balance status** any time, day or night at the Web site. In addition, the Web site has a claim form, a list of qualifying expenses, and other administrative tools that will help you conveniently manage your account. The site also has frequently asked questions and instructions on how to contact us. The Web site address is www.mbicard.com.