FLEXIBLE SPENDING ACCOUNT CLAIM FORM

HR SIMPLIFIED

A. ACCOUNT HOLDER INFORMATION -- COMPLETE FOR ALL CLAIMS (PLEASE PRINT CLEARLY)				
Employer Name:		This claim applies to the plan year ending on:		
Employee Name:	Last:	First:	Middle Initial:	
Mailing Address:	Street:	City:	State:	Zip:
Social Security Number or Employee ID:		E-Mail Address:		

PLEASE READ THE DETAILED INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS FORM

☐ **Please check box if you completed the DIRECT DEPOSIT portion on the second page.**

B. HEALTH CARE REIMBURSEMENT / MEDICAL FSA

Item #	Patient's First Name	Relationship to Employee	Date(s) of Service (example: 01/01/14 to 05/09/14)	Service Provider (Doctor Name, Pharmacy, etc)	Amount of Claim
H1					$
H2					$
H3					$
H4					$
H5					$
H6					$
H7					$
H8					$
				Total Amount	$

C. DEPENDENT CARE REIMBURSEMENT / DAYCARE EXPENSES **Future Date(s) of Service will not be processed**

Item #	Dependent's Name	Age	Date(s) of Service** From	To	Service Provider (Name & Soc. Sec. No. or Tax-ID)	Amount of Claim
D1						$
D2						$
D3						$
D4						$
					Total Amount	$

IF A RECEIPT OR BILL IS NOT SUPPLIED BY YOUR DEPENDENT CARE PROVIDER, HAVE THEM COMPLETE THE ABOVE SECTION AND SIGN BELOW. I, the undersigned, am not a dependent of the participant. I have provided day care for the dependents listed above for the periods indicated. The participant has incurred the expense for these services.

x_____ _____

Dependent Care Provider's Signature (necessary only if receipt is not provided) Date

PARTICIPANT'S STATEMENT AND SIGNATURE (PLEASE READ CAREFULLY)

To the best of my knowledge and beliefs, my statements in this Reimbursement Request Form are complete and true. I certify that I or my family member has received the service described above on the dates indicated and that expenses qualify as valid expenses under the Plan and that I have not been previously reimbursed by this or any other plan nor do I expect any of these expenses to be reimbursed elsewhere. A copy or electronic facsimile of this form shall be deemed as valid as the original.

Plan Participant's Signature	Date

Mail, Fax, or Email all requests to:

HR Simplified, Inc., 5320 West 23rd Street, Suite #350, Minneapolis, MN 55416

Toll-Free Phone: (888) 318-7472 Toll-Free Fax: (877) 723-0146

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

HR SIMPLIFIED

Email: FSA@HRSimplified.com

Instructions on completing the claim form

- Claims cannot be reimbursed without fully completing section A. of the claim form. Please make sure to enter the name of your employer, your full name, address and social security number. Sections B. and C. need to be completed when requesting reimbursement for these expenses. Number your EOBs and receipts to correspond with the "Item #" column in these sections.

  Your claim request will be returned, unless all of your information is complete!

  Please Note: Your E-mail address is optional. By entering your E-mail address you are agreeing to have information regarding your account and any additional documentation for specific claims automatically sent to your E-mail account.

- Complete the following for each itemized expense incurred:

  Patient's Name – you or your dependent

  Relationship to Employee – self, spouse, child, etc.

  Date(s) of Service – the date the expense was incurred, not the date you received a bill or when the bill was paid

  Service Provider – the name of provider of service – for Dependent Care claims this also includes the Social Security Number or Tax Identification Number (TIN) of the provider

  Amount of Claim – the amount requested for reimbursement (e.g., co-pay amounts, deductibles, co-insurance, etc.)

A. ACCOUNT HOLDER INFORMATION – COMPLETE FOR ALL CLAIMS (PLEASE PRINT CLEARLY)

EMPLOYER NAME:	MY COMPANY INC	This claim applies to the plan year ending on: 2012
EMPLOYEE NAME:	Last: SAMPLE First: JOHN	Middle Initial: A
MAILING ADDRESS*	Street: 123 OAK ST City: MY TOWN State: MN Zip: 55426	
Social Security Number or Employee ID: 123-45-6789		E-Mail Address: SAMPLE@YOURCOMPANY.COM

PLEASE READ THE DETAILED INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS FORM

B. HEALTH CARE REIMBURSEMENT / MEDICAL FSA

Item #	Patient's First Name	Relationship to Employee	Date(s) of Service (example: 01/01/12 to 05/09/12)	Service Provider (Doctor Name, Pharmacy, etc)	Amount of Claim
H1	JOHN	SELF	04/01/12 - 04/30/12	WALGREENS	$50.00
H2					$
H3					$
H4					$
H5					$
				Total Amount	$50.00

C. DEPENDENT CARE REIMBURSEMENT / DAYCARE EXPENSES **Future Date(s) of Service will not be processed**

Item #	Dependent's Name	Age	Date(s) of Service** From	To	Service Provider (Name & Soc. Sec. No. or Tax-ID)	Amount of Claim
D1	ROBERT	2	08/01/12	08/31/12	PLAYTIME DAYCARE 12-4557898	$250.00
D2						$
D3						$
D4						$
					Total Amount	$250.00

IF A RECEIPT OR BILL IS NOT SUPPLIED BY YOUR DEPENDENT CARE PROVIDER, HAVE THEM COMPLETE THE ABOVE SECTION AND SIGN BELOW. I, the undersigned, am not a dependent of the participant. I have provided day care for the dependents listed above for the periods indicated. The participant has incurred the expense for these services.

X _____ _____
Dependent Care Provider's Signature (necessary only if receipt is not provided) Date

PARTICIPANT'S STATEMENT AND SIGNATURE (PLEASE READ CAREFULLY)

To the best of my knowledge and beliefs, my statements in this Reimbursement Request Form are complete and true. I certify that I or my family member has received the service described above on the dates indicated and that expenses qualify as valid expenses under the Plan and that I have not been previously reimbursed by this or any other plan nor do I expect any of these expenses to be reimbursed elsewhere. A copy or electronic facsimile of this form shall be deemed as valid as the original.

Plan Participant's Signature	Date
John Sample	09/01/12

- For the Health Care / Medical FSA – Attach an **itemized bill or receipt** (which you should obtain from the provider of service) or the **corresponding Explanation of Benefits**, if applicable, from the carrier to this form. Canceled checks, credit card receipts, bank statements and "balance forward" bills are not acceptable forms of documentation. All over-the-counter medications are not reimbursable without a doctor's prescription. Reimbursement will be processed in accordance with the provisions of your Health Care / Medical FSA reimbursement plan and applicable law.

- For the Dependent Care FSA - Attach a receipt or bill from the provider of the service to this form. This bill/receipt must state the name and address of the provider and his/her Tax Identification Number (TIN) or Social Security Number. You will be reimbursed following claims submission - per the specifications of your plan. If there is not enough money in your account to pay the entire amount of the claim that you submit, the claim will be paid up to the amount in your account. You will not need to resubmit this claim again as additional amounts accumulate in your account, you will automatically be reimbursed up to the full amount of the claim. ****All future dates of service will not be processed.****

- Sign and date the claim form or your claim will be delayed! **No claims can be processed without an employee signature**.

- **Submit fully completed and signed claim form along with all required documentation to:**

  HR Simplified, Inc.
  Attn: Spending Account Department
  5320 West 23rd Street, Suite 350
  Minneapolis, MN 55416
  Phone: 888-318-7472
  Fax: 877-723-0146
  Email: FSA@HRSimplified.com

- **For faster reimbursement -- Please complete the DIRECT DEPOSIT section and send it with your Claim form if you have not provided this to HR Simplified, Inc.**

Direct Deposit Sign Up – Read Carefully

- By completing this portion and sending this portion with your claim form you are requesting HR Simplified, Inc. to initiate Direct Deposit for all manual claims.

BANK OR FINANCIAL INSTITUTION INFORMATION:

NAME OF BANK: _____

ACCOUNT NUMBER: _____

ROUTING NUMBER: _____

☐ CHECKING ☐ SAVINGS

I authorize HR Simplified, Inc., to initiate credit entries and, if necessary, to initiate any debit entries to correct an erroneous credit entry to my account at the DEPOSITORY (identified above), for the purpose of automatically depositing funds to my account. I acknowledge that the origination of these transactions must comply with the provisions of U.S. Law.

I understand that this authorization replaces any previous authorization and will remain in full force and effect until HR Simplified, Inc. has received written notification from me of its termination in such time and in such manner as to afford the HR Simplified, Inc. and the DEPOSITORY a reasonable opportunity to act on it.

SIGNATURE: _____ DATE: _____