CLK

CLARKSTON SCHOOL DISTRICT

FLEXIBLE SPENDING ARRANGEMENT CLAIM FORM

FOR PLAN YEAR NOVEMBER 1, 2014 *through* OCTOBER 31, 2015
AND GRACE PERIOD *through* JANUARY 15, 2016

Section I – Employee Information

Last Name, First Name	MI	Day Phone	Employee SSN
Address	City	St Zip	Email* SEE INFORMATION BELOW
☐ **Address Change**			

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above. Do not use this form for Flexi-Card transactions.
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II – Day Care Claims. Attach proper third-party documentation showing the date(s) of service, type(s) of service, cost of service, dependent's name, and provider's name and tax ID or social security number (No cancelled checks, balance forwards, or bank card receipts).
4. Complete Section III – Health Care Claims. Attach proper third-party documentation showing the date(s) of service, type(s) of service and cost (No cancelled checks, balance forwards, or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Complete Section IV - Signing the claim form. Fax or mail a signed claim form, but do not do both. Online claims status is available at www.flex-plan.com. Claims must be submitted at least two (2) full business days prior to the scheduled reimbursement date.

Section II – Day Care FSA

Start Date	End Date	Provider's Name, Tax ID/or SSN	Name of Dependent	Age	Cost
See IRC Section 129 for qualifying Day Care expenses or consult your tax advisor for more information.			**Total Day Care FSA Request $**		

Section III – Health Care FSA

Service Dates	Type of Service	Name of Provider	For Whom	Net Cost	Flexi-Card Offset? (Y/N)
Did you use your Flexi-Card for any of these expenses?		**❑No**	**❑Yes**		
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Health Care FSA Request $**		

Section IV – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Care ("HCFSA") or Day Care Flexible Spending Arrangement ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFSA or DCFSA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. *By providing an email address, I consent to receive all possible communications regarding the Plan via email. I may withdraw consent at anytime without charge by contacting Flex-Plan by phone, email, or mail. To update your email address contact Flex-Plan by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant's Signature **X**	Date

Fax completed form and documentation to:
FAX: (425) 451-7002 or toll-free (866) 535-9227

Email:
claims@flex-plan.com

Mail forms and documentation to: Flex-Plan Services, Inc.
PO Box 53250 Bellevue, WA 98015-3250

Customer Service Line: (425) 452-3500 or (800) 669-FLEX Visit our Web site at www.flex-plan.com

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