Print Form

THE EMPLOYERS ASSOCIATION
Trusted HR Advice, Tools & Training℠

FSA REQUEST FOR REIMBURSEMENT

Please Print Clearly

PERSONAL INFORMATION

Company Name _____ **Social Security #** _____

Employee Name _____ **Phone** (____) _____

Address _____ City _____ State _____ Zip Code _____

☐ Please check if this is a new address

Email _____

Important Instruction: This form is for reimbursement from your Flexible Spending & Dependent Care Accounts.

You must attach an itemized bill or explanation of benefits (EOB) for healthcare expenses showing the dates of service.
Send your completed request form, with the required documentation attached, to:

The Employers Association
Attn: FSA Services
3020 West Arrowood Road Charlotte, NC 28273
Fax to: 704.944.6076
Email to: fsa@employersassoc.com

REIMBURSEMENT REQUEST: Please complete one section for each receipt. Totals at bottom. Use additional forms as needed.

◀Date of Service (Not payment Date) | Expense Type* | Amount Requested

Patient Name - Relationship to Employee | Name of Provider

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Patient Name - Relationship to Employee | Name of Provider

EXPENSE CODE KEY

H = Hearing **D = Dental** **O = Over-the-Counter Drug**
M = Medical **V = Vision** **P = Prescription**
C = Dependent Care

Total Reimbursement

I certify that I have not previously requested reimbursement for the above expenses under this or any other plan and I am not able to receive additional insurance benefits or reimbursements from any other source for these expenses. I certify that these expenses are eligible for reimbursement in accordance with the Flexible Spending Account SPD provided by my employer. I further certify that these expenses are for eligible dependents as defined under Internal Revenue Code Sc 152.

Participant Signature (**Void if not signed**) Date Signed

Instructions for Completing Request for Reimbursement Form

1. **Personal Data (Employee Name, Social Security Number, etc.) -**
   In the spaces provided, print your name as it appears on the payroll records and enter your employee number, your correct Social Security number, and the company and plant location at which you work. Be sure to include the mailing address to which you wish your reimbursement check sent. Please indicate if this is a new address.

2. **Name of Provider -** For health care or dependent care expenses, enter the name of the person or facility that provided the service (for example, **the** doctor, clinic, day care facility, etc.). Use a separate line for each expense request.

3. **Patient Name/Relationship to Employee -** Enter your name or the name of the dependent. Enter the dependent's relationship to you (for example, spouse or child).

4. **Date of Service-** Enter the date the expense was **incurred**, not the date it was paid. **ONLY** expenses that are incurred during the plan year may be reimbursed.

5. **Reimbursement Request Amount -** Enter the amount of the incurred expense.

6. **Total Reimbursement Requested -** Add amounts of reimbursement requested and enter the total. You may submit a claim anytime and checks will be issued weekly. You have SIXTY (60) DAYS FOLLOWING the end of the Plan year to request reimbursement of expenses incurred during the Plan Year. You have SIXTY (60) DAYS FOLLOWING the date your employment ends to file claims for services incurred while employed.

7. **Employee Signature and Date -** Be sure to sign and date your request.

8. **Documentation Needed -**
   You **must** attach copies of required documentation to receive reimbursement. The required documentation includes:
   For expenses that must be submitted first to an insurance company or health care plan, attach a copy of the Explanation of Benefits (EOB) form received from the insurance company or claims administrator.
   For non-covered medical expenses, attach a statement of expense showing the diagnosis, the incurred date, and the amount of expenses (for example, a physician's bill or pharmacist's prescription or receipt).
   For dependent care expenses, attach a statement of expenses from the provider showing the dependent's name, the incurred date, and the amount of the expense. Include the provider's name, address, and taxpayer identification number on the first claim submitted for that provider.

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Charlotte, NC 28273
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Email to: fsa@employersassoc.com

If you have any questions, call the Benefits Services Department at (800) 528-2398 or (704) 522-8011.