

# Flexible Spending Reimbursement Request



Employer \_\_\_\_\_

Employee Name \_\_\_\_\_ SS# \_\_\_\_\_ Phone # \_\_\_\_\_

<p style="text-align: center;"><b>PLEASE READ CAREFULLY</b></p> <p><b>These rules apply to all reimbursement requests</b></p>	<ol style="list-style-type: none"> <li>1. For healthcare reimbursement requests, attach an Explanation of Benefits (EOB) from your health/dental plan for out of pocket expenses such as deductibles or coinsurance.</li> <li>2. For Dependent Day Care reimbursement requests, attach a third party itemized receipt to include the dependent's name, dates of service, day care provider's name, Tax ID number and address.</li> <li>3. Cash register receipts are acceptable <b>only</b> for eligible over the counter items if they include the date of purchase, the supplier's name, a clear description of the item, and the amount of the item.</li> <li>4. Cancelled checks or hand written explanations or descriptions of services are not acceptable.</li> <li>5. One claim form can be used for a combination of family members and/or expenses.</li> <li>6. Reimbursement will be made only to the individual employee.</li> <li>7. Separate claim forms must be completed for expenses incurred in different calendar years.</li> <li>8. Auto rollover participants should not request reimbursement for healthcare claims processed by FSAI. Any out of pocket expense will automatically apply to your healthcare flexible spending account.</li> <li>9. This form must be completed, signed, dated and mailed or faxed to FSAI with requested documentation.</li> </ol>
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### Un-reimbursed Healthcare Expense Claims

Patient Name	Date Expense Incurred	Name of Provider or Merchant	Expense Description	Charge
<b>TOTAL HEALTHCARE EXPENSE CLAIM</b>				

### Dependent Care Expense Claims

Name of Dependent(s)	Date(s) of Service		Name, Address and Taxpayer Identification Number of Day Care Provider	Amount Incurred
	From	To		
<b>TOTAL DEPENDENT CARE EXPENSE CLAIM</b>				

I certify that these expenses for which reimbursement is claimed from my healthcare reimbursement account or my dependent care account have been incurred to me and/or my eligible dependents during the applicable plan year and are not payable by any other plan. I further declare that I have not and will not deduct these expenses on my federal income tax returns and my employer will provide this information on request of the IRS to the IRS.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Submit completed forms and documentation to:**

First Service Administrators, Inc. • 3035 Lakeland Hills Blvd • Lakeland, Florida 33805-2225  
 Local Fax: 863.577.8039 • Toll Free Fax: 888.285.5123 • Email Address: flexadmin@firstserviceadmin.com

**\*Access your account 24/7 at [www.online-enrollment.com/FI1st](http://www.online-enrollment.com/FI1st)\***