# Flexible Spending Account
# Health Care Easy Reimbursement Request Form

benesyst

## Account Holder Information

(Please print in ALL CAPITAL letters) (i.e. A B C D E)

Participant's Daytime Phone (with Area Code first)

Participant's Social Security Number *Failure to provide your SSN may delay processing

*FSAHC01*

Participant's First Name

Participant's Last Name

Participant's Employer Name

Participant's Email Address *Automatic Opt in to receive information via email from Benesyst. Your address is kept 100% confidential.

**Participant's Statement and Signature** **PLEASE READ CAREFULLY:**

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred/rendered during a period while I was covered under the Company's Flexible Spending Account Plan with respect to such expenses and that the health care expenses are for medical care and, if applicable, have not been reimbursed or are not reimbursable under any other health plan coverage. I, the undersigned, certify that these expenses were incurred by me, or a federally eligible dependent, and are expenses permitted under federal law. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

X _____ Participant's Signature

_____ Date

## Expense Information

| **Start Date of Service** (Month-Day-Year) (i.e. 01-23-09) | NOTE: Please report only one expense per block. Combining multiple expenses in one block may result in a delayed reimbursement. | **Amount** (i.e. 24.99, do NOT include the $) |
|---|---|---|
| __ – __ – __ | Name of Provider<br>Service Type: Health RX Dental Vision OTC<br>Incurred for: Self Spouse Child Covered by Insurance: Yes No | . |
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**Please Fax Your Claim To** (800) 310-8279
Or Mail to: Benesyst Claims, 800 Washington Ave. N. 8th floor, Minneapolis, MN 55401

Total Expenses → .



DO NOT PHOTOCOPY THIS FORM



For faster processing, fill out this form on your computer before printing and faxing.
Processing is fastest when using our online claim wizard. To access the online claim wizard, log into your account at www.benesyst.net