# FLEXIBLE SPENDING
## HEALTH CARE REIMBURSEMENT CLAIM FORM

### Section A: Completed by Employee

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- ☐ Check Box if New Address
- Date of Birth (Mo/Date/Yr) ____________________
- Social Security # ____________________

### Section B: Completed if Expenses are for Spouse or Dependent

**Number of eligible dependents in your household** _____________ (do not include yourself)

Definition of eligible dependent includes spouse and any person who satisfies the definition of dependent within the meaning of Section 152 of the Code. (Will be reported as a financial dependent on your personal tax return or legally required to pay for medical expenses).

If you are divorced and are required to pay only a portion of medical expenses for dependents, please list the names and percentage you are responsible for. List dependent’s name(s) and percentages.

Name(s) and Percentages(s) % ____________________________________________________________

(Submitted expenses will be reduced by the percentage indicated)

### Section C: Spending Account Expenses (Must be completed in full)

<table>
<thead>
<tr>
<th>Description of Expense</th>
<th>Dates Incurred From - To</th>
<th>Reimbursement Amount Requested</th>
<th>Family Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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<td></td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
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</tbody>
</table>

**TOTAL:** __________________________

### Section D: Authorization

To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for eligible dependents. I certify that these expenses have not been and will not be reimbursed under any other benefit plan and will not be claimed for an income tax credit. I authorize my Flexible Spending Account to reimburse me by the amount requested. I hereby authorize any providers of health care services, suppliers, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about my health status and health care services provided to me. I further agree to reimburse the plan to the extent of any payment which is in excess of the amount payable under this plan. For dependent care claims, either the provider has signed this completed form or I have attached evidence that services were incurred.

Employee Signature __________________________ Date __________________________

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**Mail or Fax Health Care Reimbursement Claim Form and Documentation to:**
American Administrative Group, Inc.
P. O. Box 7007, Troy, MI 48007-7007
Fax: (248) 733-0373

Directions on how to file a claim are on the back of this form. If you have any questions, please call (248) 733-0353 or outside the 248 area code (800) 821-8197.
HOW TO FILE A HEALTH CARE REIMBURSEMENT CLAIM

Step One
Complete Section A in its entirety.

Step Two
Complete Section B if expenses are for spouse or dependent.

Step Three
Complete Section C. This section must be completed in its entirety for reimbursement to be made. Supporting documentation must accompany your claim:

FOR NON- OVER-THE-COUNTER MEDICAL EXPENSES

(A) Fully itemized bills (including dates of service, name patient, type of service, type of drug, etc.) from the doctor, dentist, pharmacy or other provider (cancelled checks and cash register receipts for prescriptions are not proper documentation). Credit Card receipts are only acceptable if receipt indicates date of service, type of service(s) or product(s) (if more than one type of service or product, fees must be broken out on receipt) as well as recipient’s name.

OR
Explanation of Benefit Statement page(s) indicating service date, provider, type of service, co-insurance and ineligible amounts with denial codes description not covered by any Medical/Dental Plan(s) under which you and/or any of your eligible dependents are covered.

FOR OVER-THE-COUNTER MEDICAL EXPENSES

(A) Attached fully itemized cash register receipts for over-the-counter drugs and indicate on claim form (under Section B) the number of eligible dependents. We will not reimburse sales taxes or shipping charges.

(B) If requesting reimbursement for durable medical supplies – a letter from your doctor is required to include the medical necessity as well as the length of the treatment plan.

Step Four
Complete Section D. Employee MUST sign and date the claim form.

Step Five
Retain copies of the entire claim form and supporting documentation for your records. Those submitted will not be returned to you.

Step Six
Mail the fully completed Health Care Reimbursement Claim Form and supporting documentation to: American Administrative Group, Inc., FSA Claims Department, P.O. Box 7007, Troy, MI 48007-7007 Or you may fax the form and supporting documentation to (248) 733-0373. If you are faxing – please include a cover sheet identifying name, phone number and the number of sheets you are faxing. Do not mail a hard copy, but keep your fax confirmation for submission verification.

There is an established cut-off period for receipt of claims. Typically this may be one to two business days prior to the reimbursement date. Fax claims are due by noon (Eastern Standard Time) of the cut-off date in order to be processed for the next reimbursement date.