

FSA Claim Form



Attach appropriate documentation and send completed claim form to Aon Consulting.

| | | | | |
|--|----------------------------|-----------|---|--|
| FAX | | OR | MAIL | |
| Fax #: | 1-866-887-3212 (toll-free) | | Aon Consulting Flex Administration - #0001 P.O. Box 3002 Arlington Heights, IL 60006-3002 | |
| To: | Flex Administration | | | |
| Date: | Pages: | | | |
| If you have questions call 1-877-371-2926. | | | | |

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Employee Name _____

Social Security Number

NCFlex Convenience Card Expenses

- **NCFlex Convenience Card Expenses** – Check the box below and attach copies of receipts to this claim form. You do not need to complete the Claims Information section. Sign and date the bottom of the form and fax or mail.
 - Please check this box if NCFlex Convenience Card receipts are attached.

Health Care and Dependent Day Care Expenses

- **Health Care Expenses** – Complete the Claim Information section below and attach any receipts or supporting documentation. Sign and date the bottom of the form and fax or mail.
- **Dependent Day Care Expenses** – Complete the Claim Information section below and attach any receipts or supporting documentation. In the absence of receipts or documentation, you may have your day care provider sign and complete the Provider Statement below. Sign and date the bottom of the form and fax or mail.

| Code Type* | Date Expense Incurred | Name of Person Receiving Service | Claim Amount | Provider of Service |
|---|-----------------------|----------------------------------|--------------|--------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| *Code Types: M -Medical; D -Dental; V -Vision; H -Hearing; P -Prescription Drugs; O -Over the Counter Drug; DC -Dependent Day Care | | | \$ | Total Reimbursement Requested |

Dependent Day Care Provider Statement

I provided the day care services as stated above. Tax ID# _____
 Day Care Provider Signature _____ Date _____

Employee Certification

- I certify that:**
1. The health and/or dental care expenses claimed above are not eligible for reimbursement by any insurance carrier or employer-sponsored health or dental care plan.
 2. The expenses claimed above have not been, and will not be, taken as a credit or deduction on my personal income tax return.
 3. The dependent day care expenses claimed above enable me and my spouse (if applicable) to be gainfully employed, are attributable to the care of a qualifying individual, and have not been paid to a dependent. I further certify these expenses submitted under this claim and when combined with expenses reimbursed previously this year do not exceed the lower of my or my spouse's earned income for the calendar year.
 4. Where I have not included the address and taxpayer identification number of each Dependent Day Care provider listed above, I have done so because:
 - I submitted it earlier this year, or
 - The provider is a non-profit, religious, charitable or educational organization [under Section 501(c)(3)], or
 - I was unable to obtain this information after diligently trying to obtain it.

Employee Signature _____

Date _____

Your signature is required for reimbursement. Failure to sign this form will delay processing.

Instructions for Completing Your Claim Form

Please read these directions before mailing your form. If this form is not completed correctly your request will be returned.

- A. In section "A," fill in your name and social security number.
- B. Complete section "B" if you are submitting receipts for your NCFlex Convenience Card transaction.
- C. Complete the following information in section "C" for health care and dependent day care expenses paid for out of pocket. (Do not list any expenses charged to your Convenience Card.)

- **Code Type:** Enter the code for the type of expense using the following:
 M - Medical
 D - Dental
 V - Vision
 H - Hearing
 P - Prescription Drugs
 O - Over the Counter Drug
 DC - Dependent Day Care

- **Date Expense Incurred:** Enter the date the service was provided (not the date of the bill).
- **Name of Person Receiving Service:** Enter the name of the eligible person for whom the claim is made.
- **Claim Amount:** Enter the amount requested for reimbursement. (NOTE: if you have a Health Care Explanation of Benefits to attach, enter the difference between the total expense and the amount paid by the health care plan.)
- **Provider of Service:** Enter the name of the person or facility that provided the service.

- D. Read section "D" to certify the information you have provided is accurate. Be sure to sign and date the form or your claim will be delayed. **No claims can be processed without a signature.**

Attach appropriate documentation and send completed claim form to Aon Consulting.

FAX: 1-866-887-3212 (toll-free)

OR

**MAIL: Aon Consulting
 Flex Administration - #0001
 P.O. Box 3002
 Arlington Heights, IL 60006-3002**

If you have questions call 1-877-371-2926.

Your signature is required for reimbursement. Failure to sign claim form will delay processing.

The image shows a sample FSA Claim Form with four callouts: A points to the 'Employee Name' and 'Social Security Number' fields; B points to the 'NCFlex Convenience Card Expenses' section; C points to the 'Health Care and Dependent Day Care Expenses' table; and D points to the 'Employee Certification' section.

Canceled checks and balance forward receipts are not acceptable documentation.

1. **Documentation Needed:** You must attach copies of required documentation to receive reimbursement. If documentation is not correct, you will be required to resubmit expenses with proper documentation.
 - For expenses which must first be submitted to an insurance company or health care plan, attach a copy of the Explanation of Benefits (EOB) form received from the insurance company or administrator.
 - For eligible medical expenses not covered by a health care plan, attach the provider's statement of expense showing the type of service, the incurred date and the amount of expense: For example, a physician bill(s) or pharmacist prescription label(s) or itemized receipt(s) describing items purchased.
2. Send completed and signed form (with documentation attached) to the NCFlex FSA Customer Service Center.