FLEXFACTS
a company of grant benefit solutions

Please send this form along with all applicable receipts to:
1200 River Ave, Suite 5C, Lakewood, NJ 08701
Fax: 877-747-8564 E-Mail: Claims@flexfacts.com

Spending Account Claim Form

Personal Information

Full Name: _____
Last *First* *M.I.*

Employer: _____

Last Four Digits of Your Social Security Number _____

Phone: ( ) _____ E-mail: _____

If your address has changed please list the new address below.

New Address: _____

City, State, Zip _____

Claim Information

Please enter in Medical FSA or Dependent Care FSA as the "Type of Expense" below.

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Dependent Care or Transit Certification

Please complete the following information if you are not able to get a receipt from your transit or daycare provider.

Provider Name *Service Start Date* *Service End Date*

Dependent Care Only: _____
Provider Tax ID # *Provider Signature*

Employee Signature: _____

Date: _____

- By signing this form I agree to have my account reduced by the amount requested.
- This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- If additional information is required you will receive a denial letter letting you know what additional information is needed.
- Claims incurred during a grace period will be paid out of the prior year first.
- **Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact your employer to see** if advance payments for orthodontia expenses are allowed.