Company Code CRD

COMPANY NAME: City of Redmond

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

PLAN YEAR January 1, ***through*** December 31,

Section I – Employee Information

Last Name, First Name	MI	Day Phone	Employee SSN or ID#
Address	City	St Zip	Email*

☐ **Address Change**

*By providing an email address you consent to receive electronic communications, including denials, notices, HIPAA notice of availability, summary plan and other documents that may be suggested by your plan administrator.

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above. Do not use this form for Benny™ Card transactions.
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II – Day Care Claims. Attach proper third-party documentation showing the date(s) of service, cost of service, name of child and provider's information.
4. Complete Section III – Health Care Claims. Attach proper documentation showing the date(s) of service, type(s) of service and cost **(No cancelled checks, balance forwards or bank card receipts).** Itemize all expenses to prevent delays in reimbursement.
5. Complete Section IV - Signing the claim form. Fax or mail a signed claim form, but do not do both. Online claims status is available at www.flex-plan.com. Claims must be submitted at least two (2) full business days prior to the scheduled reimbursement date

Section II – Day Care FSA

Start Date	End Date	Provider's Name, Tax ID/or SSN	Name of Dependant	Age	Cost
See IRC Section 129 for qualifying Dependant Care expenses or consult your tax advisor for more information.			**Total Day Care FSA Request**		$

Section III – Health Care FSA

Service Dates	Type of Service	Name of Provider	For Whom	Net Cost
- -				
- -				
- -				
- -				
- -				
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Health Care FSA Request**	$

Section IV – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Care ("HCFSA") or Day Care Flexible Spending Account ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFSA or DCFSA which relate to such expense. I further understand that no dependent care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. *By providing an email address, I consent to receive all possible communications regarding the Plan via email. I may withdraw consent at anytime without charge by contacting Flex-Plan by phone, email, or mail. To update your email address contact Flex-Plan by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant's Signature **X**	Date

Fax completed form and documentation to:
FAX: (425) 451-7002 or toll-free (866) 535-9227

Email:
claims@flex-plan.com

Mail forms and documentation to: Flex-Plan Services, Inc.
PO Box 53250 Bellevue, WA 98015-3250

Customer Service Line: (425) 452-3500 or (800) 669-FLEX Visit our Web site at www.flex-plan.com