FLEXIBLE SPENDING ACCOUNT CLAIM FORM

(Form FSARRF 1/10)

Claim Filing and Documentation Instructions	
1) This form is *only* for use with a Health Care or Dependent Care Flexible Spending Account. 2) Provide ALL of the information requested on the claim form. Incomplete or unclear information WILL result in processing delays. 3) For dependent care accounts: Attach receipts/statements from the provider including service dates, expense description, amount of expense, provider name, and Tax ID# (or Social Security Number).	4) For health care FSA claims: Attach an Explanation of Benefits (EOB) or *itemized* bill/statement from the provider showing the provider name, patient name, expense description, date of service, amount paid, and, if applicable, amount covered by insurance. Credit card receipts and cancelled checks are NOT acceptable. Cash register receipts are only acceptable in the case of eligible non-prescription drugs.

Check one: ☐ NEW CLAIM ☐ RESUBMITTED CLAIM (If applicable, enter date of Action Notification Letter _____.)

EMPLOYEE INFORMATION

Employer	Plan Year
Employee (First, MI, Last)	Employee ID# (or Last 4 Digits of SSN)
Department #	***FILL OUT INFORMATION BELOW ONLY IN CASE OF ADDRESS CHANGE***
Daytime Phone #	Address
E-Mail Address	City, State and ZIP Code

CLAIM INFORMATION (Please make sure the TOTAL amounts are completed)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT		
Provider Name	Date(s) of service	Amount
TOTAL AMOUNT OF HEALTH CARE FSA CLAIM (required):		

CHILDCARE/ADULT CARE FLEXIBLE SPENDING ACCOUNT		
Provider Name	Date(s) of service	Amount
TOTAL AMOUNT FOR CHILDCARE/ ADULTCARE FSA CLAIM (required):		

Employee Certification	I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents and are not payable by any other plan and will not be deducted on my federal, state, or local income tax returns. I also certify that these claims were incurred during the appropriate benefit year and that the information included is correct to the best of my knowledge. Further, I authorize release of payments through my Flexible Spending Account. _____ _____ **EMPLOYEE SIGNATURE (required)** **DATE**

Fax or mail claims to:
108 Giles Avenue, Suite 102 * Wilmington, NC 28403 * Phone (910) 791-2259 * (800) 467-2259 * Fax (910) 395-2316
For more information, visit us on the web at www.laymongroup.com. Email us at flexdepartment@laymongroup.com.
REMINDER: MBI Benefits Card users can check their account status anytime at www.benefitspaymentsystem.com.