

FLEX CLAIM FORM

You must complete, sign, date, and submit a claim form with each batch of receipts submitted.

Charleston Southern University

Submitted for Plan Year ___/___/___ - ___/___/___

Employee _____ SSN ___/___/___

Phone # _____ Email Address _____

Change of mailing or email address?

Number/Street

City

State

Zip

Non-reimbursed Medical Expenses

(1 of the 3 boxes below must be checked)

I HAVE A HEALTH SAVINGS ACCOUNT (HSA) AND I AM SUBMITTING DENTAL, VISION, AND PREVENTIVE EXPENSES ONLY FOR REIMBURSEMENT. MY HSA ACCOUNT WAS EFFECTIVE ON (MM/YY) _____.

I HAVE A HEALTH SAVINGS ACCOUNT (HSA). I'M ATTACHING AN EXPLANATION OF BENEFIT STATEMENT (EOB) FROM BCBS INDICATING I HAVE MET MY DEDUCTIBLE. I AM NOW ELIGIBLE FOR REIMBURSEMENT OF ALL IRS CODE § 213 EXPENSES.

I DO NOT HAVE A HEALTH SAVINGS ACCOUNT. I AM ELIGIBLE FOR REIMBURSEMENT OF ALL IRS CODE § 213 EXPENSES.

of Non-reimbursed medical receipts submitted _____ Reimbursement Requested \$ _____
(Please keep a copy of your receipts)

Dependent Daycare Expenses

Attach a copy of your receipt to a completed claim form **OR** have the dependent daycare provider complete and sign below (original signature required).

Dependent's name _____ Date of Birth ___/___/___

Dependent Daycare Provider _____ Tax ID or SSN _____

Date of Service ___/___/___ through ___/___/___ Amount \$ _____

Dependent Daycare Provider Signature

Date

of Dependent Daycare receipts submitted _____ Total \$ amount of receipts submitted \$ _____

I hereby certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed and will not be reimbursed under any other health plan coverage. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. I fully understand that I am responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by me, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature

Date

Submit claim form with receipts to:

Flexible Benefits Plan

National Benefit Administrators, Inc.

PO Box 690903

Charlotte, NC 28227-7016

Phone (704) 844-2966

(800) 482-6736

Fax (704) 815-2195