

NOME PUBLIC SCHOOLS CLAIM FORM

HEALTH REIMBURSEMENT ARRANGEMENT & FLEXIBLE SPENDING ACCOUNT

Flexible Spending Account: SEPTEMBER 1, 2007 through JUNE 30, 2008
Health Reimbursement Arrangement: JANUARY 1, 2007 through DECEMBER 31, 2007

Section I – Employee Information

Last Name, First Name	MI	Day Phone	Employee SSN <div style="border: 1px solid black; display: flex; justify-content: space-between; align-items: center;"> </div>
Address	City	St	Zip
<input type="checkbox"/> Address Change			
			Email

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above.
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 documentation showing the date(s) of service, cost of service, dependent’s name, and provider’s name and tax ID or social security number (No cancelled checks, balance forwards, or bank card receipts).
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 Dependent	Age	Cost
See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information.				Total Day Care FSA Request	\$

HRA Eligible Expenses: Deductible expenses associated with the employer sponsored group medical plan. Claim must be accompanied by an insurance EOB.

FSA Eligible Expenses: All section 213 expenses. Please see www.flex-plan.com for more details.

Section III – Health Reimbursement Arrangement and Health Care FSA

Service Dates	Type of Service	Name of Provider	For Whom	Net Cost
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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 Reimbursement Arrangement (HRA) or Health Care (“HCFSA”) or Day Care Flexible Spending Arrangement (“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 HRA, 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 my email address, I am requesting that all possible communications regarding this claim may be sent via email. I hereby authorize my HRA, HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant’s Signature X	Date
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Fax completed form and documentation to: (425) 709-7125 or toll-free (866) 535-9227 **Email: claims@flex-plan.com** **Mail forms and documentation to: Flex-Plan Services PO Box 53250 Bellevue, WA 98015-3250**

Customer Service Line: (425) 452-3422 or (800) 669-FLEX ext 3422 Visit our Web site at www.flex-plan.com