Please complete when faxing your claim:

Date: _____

# of Pages: _____

Return Fax #: _____

Please print clearly. Thank you!

Flexible Spending Accounts

Claim Form

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where required.

Employee Name _____ Employee Social Security # _____

Employer _____ Daytime Telephone _____ Check here if this is a change of address: ☐

Home Address _____

City _____ State _____ ZIP Code _____

Health Flexible Spending Account

Service Date	Name of Service Provider	Name of Family Member for whom Reimbursement is Requested & Relationship	Date of Birth	Service Description (Medical, Vision, Dental, Orthodontia, Rx)	Amount Requested for Reimbursement
					$
					$
					$
					$

WILL ANY OF THE ABOVE EXPENSES BE COVERED OR REIMBURSED FROM ANY OTHER SOURCE (e.g. Blue Cross, an HMO or another Employer's Insurance Plan)? ☐ **NO** ☐ **YES If** yes, you must attach copies of the other plan's explanation of benefits form.

Are you submitting request for OVER-THE-COUNTER Medications?

☐ **NO** ☐ **YES If** yes, you must attach copies of the prescription or letter of medical necessity.

Dependent Care Account

You must attach a bill or receipt showing service dates, cost and the care provider's tax ID or Social Security number or have the provider sign below in the "Provider Signature" section. If the care provider is tax-exempt, write "tax-exempt" in the space for the care provider's tax ID. Cancelled checks are not considered sufficient documentation.

Name of Dependent Receiving Care	Relationship to employee	Date of Birth	Disabled Yes No	Name of Service Provider	Provider Tax ID or Social Security no.	Service Dates From To	Amount requested For reimbursement
							$
							$
							$
							$

☐ **Continued on additional page**

Dependent Care Provider's Signature _____ **Date** _____
(Necessary only if receipt is not provided)

I have read the Summary Plan Description Reimbursement Plan and certify that the expenses listed above meet all requirements as qualified expenses.

Participant's Signature _____ **Date** _____

Submit Reimbursement requests to : **Activa Benefit Services, LLC**
P.O. Box 37
Farmington, MI 48332

Fax: (616) 588-7915
Phone: (877) 827-1414 or (616) 588-5340