

"LIMITED-USE" FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Please read these instructions before completing the claim form:

1. Employee must complete Part I.
2. Instructions for Part II "Health Care Expenses":
 - A. Expenses covered by your spouse's or your health care plan(s) must be submitted to that/those plan(s) prior to submission to your flex medical reimbursement account. Attach a copy of the explanation of benefits statement or itemized bill showing health care plan(s) payment(s) in order to claim your patient responsibility amounts.
 - B. For all other eligible health care expenses, attach an itemized receipt that clearly states the name and address of the provider, date of service, service rendered, name of person receiving the service and the amount charged.
 - C. **Effective January 1, 2011 you will need either a prescription or note of medical necessity for your Over-the-Counter medications.**
3. Read the Employee Statement, sign and date the form.
4. Mail (or fax) the completed form and any attachments to the address (or fax number) provided on this form.

Part I: Employee Information (Please Print)

Employer:			
Employee Name:		SSN:	
Address:			New Address? <input type="checkbox"/> YES <input type="checkbox"/> NO
Daytime Phone		Evening Phone	

Part II: Dental, Vision, Pharmacy (after HSA Deductible has been met), OTC Expenses (Please Print)

Covered Person	Date of Service	Provider	Amount Claimed	Administrative Use Only
Total			\$	

Employee Statement:

I request payment from my Cafeteria/Flexible Benefits Account(s) for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: _____ Date: _____

Send completed claim form to:

Health Economics Group, Inc.
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Rochester, NY 14607

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(800) 666-6690, ext. 504
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