FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Please print clearly

Claim Submissions:
Significa Benefit Services, Inc.
P.O. Box 7777, Lancaster, PA 17604-7777
717-581-1300 or 800-433-3746
For secure submission of claims with PHI, go to:
www.significabenefits.com\members
select "Submit Secure Email or Attachment"
Fax: 717-581-8379
customerservice@significabenefits.com

Employer Name:____Group #:__________________________
Name (Last, First, MI):____
Social Security Number or Member ID:____
Mailing Address:____
City:____State:______ Zip:___________________
Phone Number:__________________________Email Address:_______________________________________

Dependent Care Flexible Spending Account

Name of Dependent	Age	Dates Care Provided From To	Name and Address of Care Provider	Charges for Care
			Total Dependent Care Amount Request	

Provider EIN or SS number:____________________

I provide the dependent care as stated above.____________________________Date:______________________
Dependent Care Provider's **original** signature

Claims for future services are **not** eligible for reimbursement.

Health Care Flexible Spending Account

Complete this section to be reimbursed for eligible expenses incurred during the plan year while you were a participant. An expense covered under another benefit plan (including your spouse's benefit plan, HRA, Dental, HSA or Vision Plan) cannot be reimbursed under the flexible spending account plan until submitted to the other plan first. That plan will provide you with an Explanation of Benefits (EOB) explaining if and to what extent the plan reimbursed the expense you submitted.

Do you have coverage under another benefit plan? □ Yes □ No

List one person per form

□ Apply to Current Year □ Apply to Last Year

Name of person receiving service/ care	Relationship	Date Medical Care Provided	Name of Provider	Expense Type	Dollar amount that is your responsibility
			Total Health Care Amount Requested (Use additional pages if needed)		

I hereby certify that all items requested to be reimbursed:

- Were incurred for services or supplies received by myself or my eligible dependents;
- Comply with my employer's flexible spending account plan;
- Have not and will not be covered by any other plan or program of any employer or other person; and
- Have not been deducted or will not be deducted on my individual income tax returns.

I authorize my health care flexible spending account to be reduced by the amount requested.

Employee Signature:____Date:

Instructions

Dependent Care Expense Claims

- To prevent processing delays, complete all boxes and attach a copy of the receipt for each expense claimed.
- The receipt must include:
  - Date(s) of service
  - Name of the dependent
  - Provider's name
  - Provider's address
  - Provider's Federal I.D. or social security number
  - Amount charged for the service

Health Flexible Spending Account

- To prevent processing delays, complete all boxes and attach required documentation for each expense claimed as follows:
- For an expense covered under another benefit plan (including your spouse's benefit plan): provide the EOB
- For an expense not covered under another benefit plan (including your spouse's benefit plan): Provide an item-ized bill.
- The itemized bill must include:
  - Provider's name
  - Provider's address
  - Patient's name
  - Date of service
  - Type of service
  - Amount charged for the service

However—

- For a prescription drug/supply expense, the itemized bill must include:
  - Pharmacy's name
  - Pharmacy's address
  - Patient's name
  - Date of service
  - Description of item
  - Prescribing physician's name
  - Amount charged
- For an over the counter drug/medical supply expense (if eligible for reimbursement under you employer's plan) must include:
  - Cash register receipt showing the drug name, date of service and price
  - Physician prescription required
- Canceled checks are not acceptable receipts.

Claim Submission

Please submit the completed, signed form to:

SIGNIFICA BENEFIT SERVICES, INC.
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