



# Flexible Spending Account Health Care Claim Form

**IMPORTANT NOTE**

Please use this form when filing a claim for reimbursement only.  
**Do not** use this form when submitting receipts for debit card transactions.

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - -

Phone: \_\_\_\_\_ E-mail (Optional): \_\_\_\_\_

Please complete this claim form. Incomplete forms will be returned to you. To expedite your claim, please provide all appropriate information and review the Total Health Care Expense amount.

Date Expense Incurred	Name of Service Provider	Expense Description (Rx, co-pay, etc.)	Person for Whom Expense Incurred	Net Amount
<b>Please include copies of your receipt(s) with this claim form .</b>			<b>Total Health Care Expense Claim(s)</b>	<b>\$</b>

**Read Carefully:** By signing below, I certify the following: That the expense(s) for which reimbursement is requested were provided while I was covered under the Plan; That the health care expenses have not been reimbursed from any other source, nor will reimbursement be sought from any other source; All information provided above is complete and accurate; Unless an expense is a qualifying expense under the Plan, I will be required to repay an amount equal to such erroneous reimbursements. Failure to provide complete and accurate information regarding qualifying expenses only may result in adverse tax consequences.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Mail the claim form and copies of your receipts to: Altus Benefit Administrators, PO Box 1643, Providence, RI 02901-1643, or fax to: 401-457-7266.**



## Flexible Spending Account Health Care Claim Filing Instructions

**Please note:** Nothing in these instructions is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between these instructions and the SPD, the SPD controls.

**To qualify for reimbursement from your Health Care Spending Account, the following is required:**

1. The receipts submitted must be for health, dental, vision, over-the-counter items, or hearing expenses which are allowed by IRS regulations.
2. You, your spouse, or a dependent - as defined in Code Section 105(b) - must incur the expenses. If there is a question as to the eligibility of a particular expense or the dependency status of a particular individual, you will be contacted for more information.
3. Expenses must be incurred on or after the participant's effective date for the plan year and before the end of the plan year (or grace period, if adopted by the employer). In accordance with IRS rules, reimbursements will not be made until the expenses have been incurred. An expense is deemed "incurred" when the services giving rise to the expenses have been provided without regard to whether you have paid for the services (i.e. advance reimbursements are prohibited).

**How to file a claim**

- Complete the top portion of the claim form by filling in the employee's name and Social Security number.
- In the claims section, complete all information for each amount requested for reimbursement.
- Sign and date the claim form.
- Attach a copy of your receipts, itemized bills and any Explanation of Benefits (EOB) forms from the insurance company. Keep the original receipts for your records.
- Cancelled checks, credit cards slips or statements showing only a balance due on your account are **not** accepted as valid receipts.
- Mail or fax the claim form and copies of your receipts to:

Altus Benefit Administrators  
PO Box 1643  
Providence, RI 02901-1643

Fax: (401) 457-7266

**Important Reminder:** The Health Care Claim Form is used when filing a claim for reimbursement only. Please **do not** use this form when submitting receipts for debit card transactions.