



Company Name \_\_\_\_\_

Please mail claims to:
Independent Health Corporation
Attn: FSA Administration 716.504.1468
511 Farber Lakes Drive 800.258.3348
Buffalo, NY 14221 716.774.8092 (fax)

A - Instructions

- Complete sections B, C, D, and E (where applicable)
If expense is covered by insurance, submit to appropriate carrier
Attach explanation of benefit (EOB) from the insurance carrier or co-pay receipts
Itemized bills should include the following:
\*Provider name & address \*Patient name \*Itemized charges \*Date of service \*Type of service
Cancelled checks, cash register receipts, non-itemized receipts, and balance due bills are not acceptable proof of expenses
Be sure that your company name appears at the top of this form
All claims must be received at least five business days prior to your employer's next scheduled reimbursement date
For over-the-counter drugs, circle the eligible item(s) on your receipt. Cash register receipts are acceptable for over-the-counter drugs

B - Employee Information

Name: Social Security:
Address: Phone:
City, State: Zip:
If this is a new address, please check here [ ]

C - Healthcare Expenses (FSA / HRA)

Please indicate if you have the following types of coverage:
Medical coverage? Yes [ ] No [ ]
Dental coverage? Yes [ ] No [ ]
Vision coverage? Yes [ ] No [ ]
if yes, please be sure to provide an explanation of benefits (EOB) or co-payment receipt
Table with columns: Patient Name, Provider (Doctor/Dentist/Pharmacy), Date(s) Range for Service, Total Charges
Total Healthcare Reimbursement Request - \$

D - Dependent Care (daycare) Expenses (FSA only)

Table with columns: Child(ren) Name(s), Provider, Federal ID Number, Date of Service, Total Charges
Total Day Care Reimbursement Request - \$

E - Certification

I certify that the expenses for which I am requesting reimbursement meet all the following conditions listed below:
They were incurred for service or supplies by my eligible dependents or me under the plan.
They were for services or supplies furnished on or after the effective date of my employee spending account.
I have not been reimbursed for these expenses in any other way.

I understand the reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct my individual income tax return any of the expenses reimbursed through my Healthcare Account or my Dependent Care Account. I understand that reimbursement will be made in accordance with the guidelines set by the Internal Revenue Service and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting and liability.

Employee Signature (required) \_\_\_\_\_ Date \_\_\_\_\_