Reset

Submit

Employer:_____

Request for Reimbursement
CLAIM FORM

NAME:	Last / First / MI	**SS#**	
ADDRESS:	Street / City / State / ZIP	**Home Phone**	( )

☐ Please check if this is a new address

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

nformation below must be completed

FLEXIBLE SPENDING ACCOUNT (FSA) MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Description of Services	Name of Provider	Claim Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total:	$ 0.00

DAY CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id# /SS#	Claim Amount
							$
							$
							$ 0.00

INDIVIDUALLY OWNED HEALTH INSURANCE CLAIMS

Premium Expense From	To	Name of Person Premium Covers	Insurance Carrier Name	Description of Policy	Claim Amount
					$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other lan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account s deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

FAX TO (661) 280-2016

OR MAIL TO: SHAFFER INSURANCE SERVICES, INC. BENEFITS DIVISION
902 EAST AVENUE Q-9, PALMDALE, CA 93550-4735
(661) 575-9331 TOLL FREE: (866) 412-5872