

# FSA Claim Form



Fax Information		Mailing Information
Fax #:	1-866-887-3212	<b>Aon Consulting</b> <b>Flex Administration - #00001-80</b> <b>P.O. Box 2845</b> <b>Winston-Salem, NC 27102-2845</b> <b>1-877-371-2926</b>
To:	Flex Administration	
Date:	Pages:	

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\_\_\_\_\_  
**Employee Name**

\_\_\_\_\_  
**Social Security Number**

**NCFlex Convenience Card Expenses** — Do not enter NCFlex Convenience Card expenses below. Attach copies of receipts to this claim form. Keep copies of the originals.

Please check this box if NCFlex Convenience Card receipts are attached.

**Health Care Expenses** — If you did not use an NCFlex Convenience Card to pay for your health care expenses, enter your claim information below.

Code Type*	Date Expense Incurred	Name of Person Receiving Service	Claim Amount	Provider of Service
<small>*Code Types: M-Medical; D-Dental; V-Vision; H-Hearing; P-Prescription; O-Over the Counter Drug; DC-Dependent Care</small>			\$	<b>Total Reimbursement Requested</b>

**Dependent Day Care Expenses** — Send copies of records supporting each listed item of expense or have your day care provider sign and date the statement below with their tax identification, signature, and date.

I provided the day care services as stated above. Tax ID# \_\_\_\_\_

Day Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**I certify that:**

1. The health and/or dental care expenses claimed above are not eligible for reimbursement by any insurance carrier or employer-sponsored health or dental care plan.
2. The expenses claimed above have not been, and will not be, taken as a credit or deduction on my personal income tax return.
3. If I am filing a claim for my domestic partner, the domestic partner meets the eligibility requirements for income tax dependents under IRC §152(a).
4. The dependent day care expenses claimed above enable me and my spouse (if applicable) to be gainfully employed, are attributable to the care of a qualifying individual, and have not been paid to a dependent. I further certify these expenses submitted under this claim and when combined with expenses reimbursed previously this year do not exceed the lower of my or my spouse's earned income for the calendar year.
5. Where I have not included the address and taxpayer identification number of each Dependent Day Care provider listed above, I have done so because:
  - I submitted it earlier this year, or
  - The provider is a non-profit, religious, charitable or educational organization [under Section 501(c)(3)], or
  - I was unable to obtain this information after diligently trying to obtain it.

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


\_\_\_\_\_  
**Date**

**Your signature is required for reimbursement. Failure to sign this form will delay processing.**

# Instructions for Completing Your Claim Form

FSA Claim Form

*Please read these directions before mailing your form. If this form is not completed correctly your request will be returned.*

		<b>Paid Information</b> Plan # 7-999-887-3212 Plan Administration LHM	<b>Filing Information</b> Aon Consulting Plan Administration - #00001-80 P.O. Box 2845 Winston-Salem, NC 27102-2845 7-877-371-2926
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- A. In section "A," fill in your name and social security number.
- B. In section "B," fill out the appropriate area depending on what type of expense you have incurred. There are separate areas for health care and dependent day care expenses.

**A** → Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

**B** →  NCPLEX Convenience Card Expenses — Do not enter NCPLEX Convenience Card expenses below. Attach copies of receipts to this claim form. Keep copies of the receipts.  
 Please check this box if NCPLEX Convenience Card receipts are attached.

**C** → **Health Care Expenses** — I you did not use an NCPLEX Convenience Card to pay for your health care expenses, enter your claim information below.

Code Type	Enter Expense Amount	Name of Person Receiving Service	City/Town	Provider of Service

\* Code Types: M-Medical; D-Dental; V-Vision; H-Hearing; P-Prescription Drugs; O-Over the Counter Drug; DC-Dependent Day Care

- C. Complete the following information in section "C":  
 (Do not list any expenses charged to your Convenience Card.)

- **Code Type:** Enter the code for the type of expense using the following:  
 M - Medical  
 D - Dental  
 V - Vision  
 H - Hearing  
 P - Prescription Drugs  
 O - Over the Counter Drug  
 DC - Dependent Day Care

- **Date Expense Incurred:** Enter the date the service was provided (not the date of the bill).
- **Name of Person Receiving Service:** Enter the name of the eligible person covered under the claim.
- **Claim Amount:** Enter the amount requested for reimbursement. (NOTE: if you have a Health Care Explanation of Benefits to attach, enter the difference between the total expense and the amount paid by the health care plan.)
- **Provider of Service:** Enter the name of the person or facility that provided the service.

- D. Read section "D" to certify the information you have provided is accurate. Be sure to sign and date the form or your claim will be delayed. **No claims can be processed without a signature.**

**D** → Employee Signature \_\_\_\_\_ LHM \_\_\_\_\_  
 Your signature is required for reimbursement. Failure to sign this form will delay processing.

**Dependent Day Care Expenses** — Send copies of records supporting each listed item of expense to have your day care provider sign and date the statement below with their identification, signature, and date.  
 I provided the day care services stated above. For ID# \_\_\_\_\_  
 Day Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

1. Do not submit:  
 1. The health care expense claim above if you are eligible for reimbursement by any health care or employer-sponsored health or dental plan.  
 2. The expense claim above if the provider, you will not be, is a creditor or executor of the person to whom you claim.  
 3. If you are a claim for a medical provider, the amount of payment for the eligible individual or become an expense under the plan.  
 4. The expense claim above if you are able to use any other health care plan, including a health care plan, to pay for the expense.  
 5. Where the expense is for a service and is payable for the number of each Dependent Day Care provider above, it has some exceptions:  
 - You have a health care plan.  
 - The provider is not your regular, credible or established organization under Section 501(c)(3).  
 - It is not able to submit a bill to the provider if you are not able to submit it.

**Canceled checks and balance forward receipts are not acceptable documentation.**

1. **Documentation Needed:** You must attach copies of required documentation to receive reimbursement. If documentation is not correct, you will be required to resubmit expenses with proper documentation.
- For expenses which must be submitted to an insurance company or health care plan, attach a copy of the Explanation of Benefits (EOB) form received from the insurance company or administrator.
- For eligible medical expenses not covered by a health care plan, attach the provider's statement of expense showing the type of service, the incurred date and the amount of expense: For example, a physician bill(s) or pharmacist prescription label(s) or itemized receipt(s) describing items purchased.
2. Send completed and signed form (with documentation attached) to Aon Consulting.

**If you have questions call 1-877-371-2926. Please attach the required documentation to this form and send to:**

**MAIL: Aon Consulting  
 Flex Administration - #00001-80  
 P.O. Box 2845  
 Winston-Salem NC 27102-2845**

**FAX: 1-866-887-3212 (toll-free)**

**You must either submit a claim online or use this form for manual submission.**

**Your signature is required for reimbursement. Failure to sign claim form will delay processing.**