Flexible Spending Account (FSA) *Health Care Easy Reimbursement Request*

NO FAX COVER SHEET IS NECESSARY IF FAXING

⇧ PLEASE INSERT TOP END OF FORM INTO FAX ⇧

To: Benesyst FSA Department	Date:	REQUIRED: Your Social Security Number	
From (Last Name, First Name):	Your Fax Number: ( ) -	☐☐☐-☐☐-☐☐☐☐	
Your Daytime Phone Number: ( ) -	Total Pages:	Employer AND Division, If Applicable:	Participant's Daytime E-mail Address:

Participant's Statement and Signature

PLEASE READ CAREFULLY:

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred/rendered during a period while I was covered under the Company's Flexible Spending Account Plan with respect to such expenses and that the health care expenses are for medical care and, if applicable, have not been reimbursed or are not reimbursable under any other health plan coverage. I, the undersigned, certify that these expenses were incurred by me, or a federally recognized dependent, and are expenses eligible under federal law. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

- IMPORTANT: Use TWO forms if expenses are from different plan years.
- Requests for the current benefit plan year must be received by Benesyst before the run-out period ends.
- Please keep your originals and either fax or mail 8½" x 11" copies of documentation for the expenses included on this form together with this form. Benesyst is unable to return documents submitted. If the form is not completed in its entirety it may be returned to you to complete and it will delay your reimbursement.
- Please Note: an eligible receipt must include ALL of the following: Provider's Name, Date of Service, Description of Service and Patient Responsibility. Your claim will be processed and appear on the Benesyst website (www.benesyst.net) five (5) business days after receipt.

X _____ _____

Plan Participant's Signature **Date**

Medical, Dental & Vision Care Reimbursement Section *(Submit Explanation of Benefits (EOB) if covered by insurance. No insurance? Attach Itemized bills)*

Date of Service Use different forms for different plan years	Name of Clinic or Store	Expense Description (e.g. Co-pay, RX, Ortho, Crowns, Glasses)	Person For Whom Expense Incurred (self, spouse, child)	Is this expense covered by insurance? Yes	No	Net Amount of Expense (The amount paid out of your own pocket, after insurance)
				☐	☐	$
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TOTAL HEALTH CARE EXPENSE REQUEST (this page only, use as many forms as needed):						$

MAKE PHOTOCOPIES OR OBTAIN ADDITIONAL FORMS THROUGH BENESYST'S WEB SITE AT HTTP://WWW.BENESYST.NET

Mail or Fax (not both) all requests to:

Benesyst, Inc./ 800 Washington Avenue North, 8th Floor, Minneapolis, MN 55401/ Fax:612-338-7969 or 800-310-8279/ Ph: 612-338-7131 or 800-670-7131