

Roman Catholic Diocese of Lexington



Flexible Spending Account (FSA)
Claim Reimbursement Request Form

| COMPANY INFORMATION (PLEASE PRINT) | |
|------------------------------------|--------------------------|
| Company Name | Division (if applicable) |

| EMPLOYEE INFORMATION (PLEASE PRINT) | | | |
|--|---|------------------|-------|
| First Name | | Home Phone () - | |
| Last Name | | Work Phone () - | |
| SSN | Email address (For notification of Processed Claims, Reimbursements & Account Status) | | |
| Street Address (Check if New Address <input type="checkbox"/>) | | | Apt # |
| City | State | Zip | |
| If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information: | | | |
| NAME | RELATIONSHIP TO EMPLOYEE | DATE OF BIRTH | |
| | | / / | |
| | | / / | |
| | | / / | |

| REIMBURSEMENT REQUEST (PLEASE PRINT) | |
|--|---|
| Please indicate your qualifying expenses below. DO NOT include expenses reimbursed by any other source. | |
| HEALTHCARE – FLEXIBLE SPENDING ACCOUNT (FSA) | |
| Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim. | |
| DATE RANGE OF SERVICES | From / / through / / |
| DESCRIPTION (Please list a brief description below of services – ie: RX, CoPay, Contact Solution, etc.) | TOTAL Healthcare Reimbursement Request \$ _____ (REQUIRED) |
| | |
| IMPORTANT: If this is a Limited Healthcare (LFSA) – ONLY submit claims for Dental and/or Vision Expenses | |

| DEPENDENT CARE (Daycare) - FLEXIBLE SPENDING ACCOUNT (FSA) | | |
|---|-----------------------------|---|
| The following information is REQUIRED: Tax ID (or SSN) & Business Name; dates of service and the expense amount; either a receipt/bill OR your Providers Signature below. NOTE: Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim. | | |
| DATE RANGE OF SERVICES | From / / through / / | TOTAL Dependent Care Reimbursement Request \$ _____ (Required) |
| PROVIDERS TAX ID (or SSN) | PROVIDER'S BUSINESS or NAME | |
| | | |
| Dependent Care Provider's Signature | Date / / | |

| CLAIM CERTIFICATION | |
|---|----------|
| I certify these expenses for which reimbursement is requested on my Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) & are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return. | |
| Signature: | Date / / |

| SEND THIS FORM & A COPY OF RECEIPTS TO CHARD SNYDER (DO NOT SEND ORIGINAL RECEIPTS) | |
|---|--|
| Please submit this form with your required documentation to Chard Snyder via one of the | <input type="checkbox"/> Fax to: Local (513) 459-9947 /Toll Free (888) 245-8452 (Please DO NOT include a Fax Cover Page) <input type="checkbox"/> Mail to: 3510 Irwin Simpson Rd, Mason, OH 45040 |

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three methods listed to the right.

Email to: askpenny@chard-snyder.com