FLEXIBLE SPENDING ACCOUNT CLAIM FORM

HR SIMPLIFIED

A. ACCOUNT HOLDER INFORMATION -- COMPLETE FOR ALL CLAIMS (PLEASE PRINT CLEARLY)				
EMPLOYER NAME:		This claim applies to the plan year ending on:		
EMPLOYEE NAME:	Last:	First:	Middle Initial:	
MAILING ADDRESS:	Street:	City:	State:	Zip:
Social Security Number or Employee ID:		E-Mail Address:		

B. HEALTH CARE REIMBURSEMENT / MEDICAL FSA

Item #	Patient's First Name	Relationship to Employee	Date(s) of Service (example: 01/01/14 to 05/09/14)	Service Provider (Doctor Name, Pharmacy, etc)	Amount of Claim
H1					$
H2					$
H3					$
H4					$
H5					$
H6					$
H7					$
H8					$
				Total Amount	$

PARTICIPANT'S STATEMENT AND SIGNATURE (PLEASE READ CAREFULLY)

To the best of my knowledge and beliefs, my statements in this Reimbursement Request Form are complete and true. I certify that I or my family member has received the service described above on the dates indicated and that expenses qualify as valid expenses under the Plan and that I have not been previously reimbursed by this or any other plan nor do I expect any of these expenses to be reimbursed elsewhere. A copy or electronic facsimile of this form shall be deemed as valid as the original.

Plan Participant's Signature	Date

Mail, Fax, or Email all requests to:
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Toll-Free Phone: (888) 318-7472 Toll-Free Fax: (877) 723-0146
Email: FSA@HRSimplified.com