HEALTH CARE FSA CLAIM FORM

Mail or Fax To:
BAS
P.O. Box 62407
King of Prussia, PA 19406
FAX: 1.888.265.2144

Please type or print legibly.

EMPLOYEE'S NAME

* FULL NAME
* SOC. SEC. # * EMPLOYER

* EMPLOYEE'S STREET ADDRESS * CITY * STATE * ZIP

Please complete this Dependent Section only if you are submitting claims for a dependent. Please note: A separate claim form must be used for each dependent's claims.

DEPENDENT'S NAME

FULL NAME

DATE OF BIRTH SOC. SEC. #

CLAIM EXPENSE INFORMATION

CLAIM YEAR

* DATES OF SERVICE (MM/DD) FROM	TO	* HEALTH CARE PROVIDER'S NAME

HEALTH CARE REIMBURSEMENT ACCOUNT CERTIFICATION

I certify that the expenses submitted herewith were incurred during the plan year and qualify for reimbursement as expenditures for medical care and not merely for general h
have been incurred and paid by my spouse, my eligible dependent(s), or me and have not or will not be reimbursed from any other health plan, insurance, or any other sourc
claimed as deductions in filing income tax returns. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing my plan for the expense.

X

EMPLOYEE'S SIGNATURE DATE

* Benefit Allocation Systems, Inc. / MyEnroll.com does not insure benefits under the health care flexible spending account plan. Your employer is solely responsible for determ
amounts due under the plan. Refer to the plan documents for more details.

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