STATE OF WASHINGTON
MEDICAL FLEXIBLE SPENDING ARRANGEMENT (FSA) & DEPENDENT CARE ASSISTANCE PROGRAM (DCAP) CLAIM FORM

FOR PLAN YEAR JANUARY 1, 2016 *through* DECEMBER 31, 2016
All claims for 2016 plan year must be submitted to Navia Benefit Solutions by March 31, 2017

Instructions

1. Complete Section I – Employee Information. Use this form only for services incurred during the plan year shown above. Do not use this form for debit card transactions.
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II if enrolled in DCAP – Attach day care claim documentation showing the date(s) of service, type(s) of service, cost of service, dependent's name, and provider's name and tax ID or Social Security number (SSN) (no cancelled checks, balance forwards, or bank card receipts).
4. Complete Section III if enrolled in Medical FSA – Attach health care claims documentation showing the date(s) of service, type(s) of service, and cost (no cancelled checks, balance forwards, or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Complete Section IV - Signing the claim form. Fax or mail your signed claim form, but do not do both. You can go to http://pebb.naviabenefits.com to view the status of your claim.

Section I – Employee Information

Last Name, First Name	MI	Day Phone	SSN (Employee I.D. if higher education):
Address	City	State Zip	Email - See information in Section IV
☐ **Address Change**			

Section II – Day Care Claims*
***Claims for future services will not be accepted.**

Start Date	End Date	Provider's Name, Address, Tax ID or SSN	Name of Dependent	Age	Cost for care period
Provider's Signature and Date					
See IRC Section 129 for qualifying day care expenses or consult your tax advisor for more information.			**Total DCAP Request $**		

Section III –Medical FSA Claims

Service Dates	Type of Service (Give general description)	Name of Provider	For Whom	Net Cost	Is this replacing a previous ineligible debit card charge? (Y/N)
Did you use your debit card for any of these expenses?			❑**No**	❑**Yes**	
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Medical FSA Request $**		

Section IV – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand it is my responsibility to ensure this claim from my Medical FSA or DCAP account and all information related to this claim is complete, accurate, and truthful. I understand I may be liable for the payment of all related taxes including federal income tax for an ineligible expense paid from the account. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. Any health care reimbursement claims are for eligible medical care expenses incurred by myself, spouse, or dependents during the plan year shown above and I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. By providing an email address, I agree to receive all possible communications about this benefit via email. I may withdraw consent at any time without charge by contacting Navia Benefit Solutions by phone, email, or mail. I authorize my Medical FSA or DCAP account to be reduced by the amount(s) shown above.

Participant's Signature **X**	Date

Completed Forms and supporting documentation can be faxed, emailed or mailed to: (425) 451-7002 or toll-free (866) 535-9227, claims@naviabenefits.com or Navia Benefit Solutions PO Box 53250 Bellevue, WA 98015-3250

Customer Service: (425) 452-3500 or (800) 669-3539; visit our web site at http://pebb.naviabenefits.com