State of California

FlexElect Reimbursement Claim Form

Please read **requirements** on reverse side

FlexElect Plan Year 20 ____

Last Name, First Name, MI (Please Print) _____ Daytime phone number _____ Social Security Number _____

Street Address _____ City, State, Zip _____

Dependent Care Reimbursement Account (day care, babysitting, etc.)

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	Age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period	ASIFlex use only
		From	To*			
		Total Dependent Care Amount Requested →				

I provided the dependent care as stated above. _____ _____ _____

Care Provider's **original** signature Date SSAN/Tax ID#

***Claims for future services are not eligible for reimbursement.**

Medical Reimbursement Account

Date Medical Care **Provided** **(Arrange documentation in same order)**	Name of Medical Provider	General Medical Expense Description. Include medical condition for over-the-counter items.	Person for whom expense incurred	Relationship	Amount	ASIFlex use only
	Total Medical Amount Requested →					

Please submit a DETAILED STATEMENT OF SERVICES or INSURANCE EXPLANATION OF BENEFITS (EOB) statement for each expense you are claiming. Credit card receipts or statements with a previous balance are not sufficient documentation.

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care Assistance expenses were provided for my dependent under the age of 13 or for my dependent who is incapable of self care. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ Date _____

ASIFlex
P. O. BOX 6044
COLUMBIA MO 65205-6044
Internet http://www.asiflex.com

← Submit Form to ASIFlex **ALONG WITH SUPPORTING DOCUMENTATION**
Toll-free fax (877) 879-9038
Online Claims Submission https://my.asiflex.com

Claim Filing Requirements

1. ***Print your name, address, social security number and your daytime phone number (optional).***

2. ***List expenses by date & arrange the supporting statements in the same order.*** Please circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
   - Day care claims - complete the Dependent Care Reimbursement Account section
   - Health care claims - complete the Medical Reimbursement Account section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

3. ***Enclose required documentation**.*** A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing all of the following:
   - The name of the dependent care or medical service provider,
   - The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
   - A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),
   - The name of the person or persons receiving the medical or dependent care, and
   - The cost of the service, not just the amount paid.

   ***Dependent Care claims only. -** You may either provide documentation from the day care provider or have the provider complete the Dependent Care Reimbursement section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

   Requests filed without the above documentation cannot be processed and will be returned.

4. ***Sign*** the claim form.

5. ***Keep*** copies for your tax records.

6. ***Mail*** to the address on the front of this form, submit the claim online, or ***Fax to (877) 879-9038***. This is a toll-free number but employee use of an office fax machine may not be appropriate. Please check with your employer before using an office fax machine.

Online Claims Submission: In order to submit claims online, you must 1) have high-speed internet access, 2) be able to scan your supporting documentation into one or more PDF files that are less than 8MB in size each, and 3) know your P.I.N., which you can find on your enrollment confirmation, or you may obtain by calling ASIFlex's customer service center (800) 659-3035. The website for online claims submission is https://my.asiflex.com. **Emailed claims will not be accepted.**

Over-the-counter (OTC) medicines & drugs: Additional filing requirements for plans allowing these under the medical FSA:

- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- **Starting with purchases January 1, 2011 forward, Federal law requires that you include a prescription in order to be reimbursed for OTC drugs and medicines** (e.g. pain relievers, allergy/cold meds, antacids, etc.). This law does not include OTC supplies such as contact lens solution, band-aids, etc.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.

Claims payment and account information available 24 hours a day 7 days a week: - Complete history including available funds online at www.asiflex.com (Account Detail). You will need your P.I.N., which you can find on your enrollment confirmation, or you may obtain by calling ASIFlex's customer service center (800) 659-3035.

Claim forms: You may copy this form, obtain forms online at http://www.asiflex.com, or request them from your personnel office.

Resources

Customer Service:	*(800) 659-3035*	***Toll-Free Claims Fax:***	*(877) 879-9038*
Customer Service Email:	*asi@asiflex.com*	***Customer Service Website:***	*www.asiflex.com*
Online claims submission:	*https://my.asiflex.com*	***Claims mailing address:***	*P.O. Box 6044 Columbia, MO 65205*