MAIL TO:
PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
Toll-Free (866) 887-3539
Toll-Free (866) UTS-FLEX

Health/Dependent Care Flexible Spending Accounts Claim Form

FAX TO:
PayFlex Systems USA, Inc.
Toll-Free (877) 230-4283
(No Cover Page Required)
Page 1 of _____

For additional information regarding eligible expenses and claim filing, please visit our website at: **www.utflex.com**.

Employee Name _____ **SSN** _____-_____-_____

Employer Name _____

Note: To make an address change, please contact your employer's HR/Benefits department. For security purposes, we cannot accept address changes directly.

Health Care Claims (For you or your dependents) - For additional information, please visit our website at: **www.utflex.com**.

Covered by insurance - Expenses for services or items must be submitted to your insurance company *before* submitting for reimbursement under your flexible spending account. When you receive the **Explanation of Benefits Statement (EOB)** from your insurance company, include a copy with this completed claim form. If you have a copay, attach an itemized statement from your service provider. Do not submit expenses previously paid for with your PayFlex Debit Card.

Not covered by insurance - For services or items, submit an itemized statement from the provider showing the provider's name and address, patient name, date the service was provided, a description of the service, and the amount charged along with this completed claim form. Balance forward statements, cancelled checks, credit card receipts or received-on-account statements are not acceptable. Orthodontia claims require an itemized statement/payment receipt, the orthodontist's contract/payment agreement or monthly payment coupons.

Prescription and over-the-counter drugs and medicines require a print-out of prescriptions from your pharmacy or must be clearly identifiable on an itemized receipt. Quantities purchased must be reasonably able to be consumed during the current plan year. Items for maintaining general good health, cosmetic purposes and dietary supplements are not eligible.

Date of Service	Type of Service (Ex. – Prescription, Over-the-Counter, Vision, Dental, Hearing, Office Visit, etc…)	Amount Requested	Date of Service	Type of Service (Ex. – Prescription, Over-the-Counter, Vision, Dental, Hearing, Office Visit, etc…)	Amount Requested
				Total	$

Dependent Child or Adult Day Care Claims - For additional information, please visit our website at: **www.utflex.com**.

Complete this form and attach an itemized statement from your day care provider or have your provider complete the information below. **IRS regulations allow payment of services for dependents under age 13 or otherwise satisfying the "Qualifying Person Test" as described in IRS Publication 503. Payment is only allowed for services that have already been provided, not for services to be provided in the future.** You are required to report the provider's name, address and Tax Identification Number or Social Security Number on Form 2441 with your personal income tax return. If your day care provider completes and signs this form below, no other itemized statement is necessary.

Exact Dates of Service		Dependent Name	Amount Requested
From	To		
		Total	$

Day Care Provider Information:	*Day Care Provider Information:*
Name _____	***Name*** _____
Provider Signature _____	***Provider Signature*** _____

I certify that these eligible expenses have been incurred by me, my spouse or eligible dependent and medical expenses are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I understand that "incurred" means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature _____ **Date** _____

****Make copies for yourself, since these documents will not be returned. If you fax your claim, keep the original.****

Rev. 10/2006