limited purpose eflexFSA

LPFSA Claim Form

Employee ID _____ Employee Name _____

Employee ID=first initial, last name (up to 8 characters), and last 4 digits of Social Security No. Example: jsmith1234

Employee email _____ ❑ Check here if this is a new email address.

Help us go green! If you provide your email address, we'll use it as our primary method of contact.

Employer Name _____

Employee Address _____ City _____

State _____ ZIP _____ Phone _____ ❑ Check here if this is a new address

Expenses—*Please complete the information below for each eligible expense. If you're contributing to a health savings account (HSA) this year, you may use this FSA for preventive services, dental, vision, and post-deductible services only. Include documentation (i.e., receipt showing date of service, description of expense, and name of service provider) for each expense.* If you have an HSA, then this FSA can only be used for Vision, Dental, Preventative and Post Deductible medical expenses

❑ Check here if you're submitting eflex Card verification receipts.

Date(s) of Service	Description	Dollar Amount
		$
		$
		$
		$
		$
	Claim Total:	**$**

I certify that the expenses for reimbursement requested from my Limited Purpose Flexible Spending Account (LPFSA) were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, were for preventive services, dental, vision, or post-deductible services , and to the best of my knowledge and belief, are eligible for reimbursement under my LPFSA. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature_____ Date _____

Reminders

- Provide proper documentation for all expenses submitted; keep this claim form and the supporting documentation together.
- Sign and date this form; we can't process an unsigned form.
- Multiple expenses may be included on one form; if you need more space, copy and attach additional forms.
- The minimum reimbursement amount is $10.
- Keep copies of everything you submit to eflex. There is a $25 fee if you request copies of your claim and documentation from eflex. IRS guidelines require we keep records of all claims and correspondence for three years.

Please fax, email, or mail completed form with documentation to:
Toll Free Fax: 1.877.231.1287 • email: customercare@eflexgroup.com
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