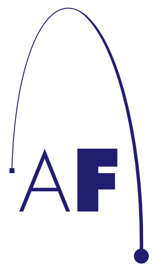
AMERIFLEX®

SPENDING ACCOUNT CLAIM FORM



☐ Designate the number of pages included in transmission when using this form as a fax cover page.

Employee Name: ______________________________

Company Employed By: ______________________________

Employee Social Security # ________-________-________ Employee Phone #: ________-________-________

IRS Ruling (applies to all accounts below): We cannot accept credit card receipts/statements as eligible proof of expense.

Flexible Spending Accounts

Medical Flexible Spending Account

Please attach/enclose appropriate proof of eligible medical expense. The itemized receipt should list: date of service, paid charges, and service provided.

Date(s) of Service(s):	**Type of Expense(s):**	**Requested Amount:**
________________	________________	$________________

Dependent Day Care Flexible Spending Account

Please attach/enclose receipt or statement from daycare provider listing: name/tax id# of provider, name of child, and date of service. Dependent care is reimbursed after service is provided, not when the bill is paid.

Date(s) of Service(s) From –To:	**Tax ID# of Provider and Type of Service** (i.e., Day Care, Pre-K, Day Camp, etc.)	**Name of Child(ren):**	**Requested Amount:**
		________________	
		________________	
________________	________________	________________	$__________

Healthcare Reimbursement Account / Employer Funded (HRA)

Please attach/enclose appropriate proof of eligible medical expense. The itemized receipt should list the date of service, paid charges, and service provided.

Date(s) of Service(s):	**Type(s) of Expense:**	**Requested Amount:**
________________	________________	$ ________________

Health Savings Account (HSA)

Date of Service: __________ **TOTAL Requested Amount: $** __________

Transit Expense (CRA)

Date(s) of Service(s): __________ **TOTAL Requested Amount: $** __________

Parking Expense (CRA)

Date(s) of Service(s): __________ **TOTAL Requested Amount: $** __________

To the best of my knowledge and belief, my statements on this claim form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these have not been previously reimbursed on this or any other benefit plan, will not be reimbursed elsewhere, and will not be claimed as an income tax deduction. I authorize my account(s) to be reduced by the amount requested. To avoid delays in reimbursement, please sign and date this claim form and provide notice of any name or address change. When faxing, use this form as a fax cover page.

Employee Signature: ______________________________ Date: ______________

Mail: 700 East Gate Drive, Suite 510, Mount Laurel, NJ 08054
Attention: Claims Department

Fax: 856.631.1020
Attention: Claims Department

Please allow 2–3 weeks for check delivery. To receive direct deposit for reimbursements, please visit out website at www.flex125.com and complete an employee direct deposit form. Please allow 5–7 business days for Direct Deposit.