



# Reimbursement Request

Date _____
FAX - # Pages _____

Please follow the steps below to thoroughly and accurately complete this form.

**STEP 1:** Company Name \_\_\_\_\_ Day Phone \_\_\_\_\_

**STEP 2:** Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

**STEP 3: FLEXIBLE SPENDING ACCOUNT CLAIMS**

Date of Service (MM/DD/YYYY)	Name of Provider	Description of Service	Claim Amount
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$

**STEP 4: CHILD/DEPENDENT CARE CLAIMS**

Date of Service (MM/DD/YYYY)	Name of Provider	Provider Tax ID/SS#	Description of Service	Claim Amount
				\$
				\$
				\$
				\$

<b>Total</b>	<b>\$</b>
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Payout Schedule – Claim Reimbursement Checks are distributed twice a month.

If claims are received by 5 p.m. on the 5<sup>th</sup>/20<sup>th</sup> of the month, reimbursement checks/reports will be sent to the employer by the 15<sup>th</sup>/30<sup>th</sup>.

**STEP 5: EMPLOYEE CERTIFICATION**

I certify that the expenses for which I am seeking reimbursement from the Flexible Spending Account have been incurred by me, or by an individual who qualifies as my spouse or my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

I further certify that the above dependent care expenses are for the care of a Qualifying Person and do not include separate charges for food, clothing, education, entertainment, activities, late fees, or overnight care. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

**Sign Here ► Signature of Employee** \_\_\_\_\_ **Date** \_\_\_\_\_

**Submit a Reimbursement Request in four easy steps....**

- Provide acceptable proof of paid expenses. We request that you send COPIES of your proof of expenses since they will not be returned to you. For tax purposes, you should retain the original proof of expense.  
Flexible Spending Account – A copy of the explanation of benefits sent to you by your carrier stating the portion of the claim paid **OR** a copy of the bill from the provider stating the services and date performed and method of payment used.  
Child/Dependent Care – A copy of receipt from care facility, referencing their tax I.D. number (or SS#) and the dates of coverage.
- Write the total amount for reimbursement which can be found in Step 4.
- Attach all copies pertaining to your claim to this form and fax to **1-847-332-0335**.
- Send request for reimbursement via mail or fax to: **Aetna FSA**  
**10275 W. Higgins Road, Suite 500**  
**Rosemont, IL 60018**  
**Phone: 1-866-472-0897**  
**Fax: 1-847-332-0335**