Flexible Spending Account (FSA)
Claim Reimbursement Request Form

CHARD SNYDER

COMPANY INFORMATION (PLEASE PRINT)	
Company Name	Division (if applicable)

EMPLOYEE INFORMATION (PLEASE PRINT)		
First Name		Home Phone ( ) -
Last Name		Work Phone ( ) -
SSN	Email Address (For Notification of Processed Claims, Reimbursements & Account Status)	
Street Address (Check if New Address ☐)		Apt#
City	State	ZIP

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /
		/ /
		/ /

REIMBURSEMENT REQUEST (PLEASE PRINT)

Please indicate your qualifying expenses below. **DO NOT include expenses reimbursed by any other source**.

HEALTHCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

DATE RANGE OF SERVICES	From / / through / /	TOTAL Healthcare Reimbursement Request
DESCRIPTION (Please list a brief description below of services – ie: RX, CoPay, Contact Solution, etc…)		$ _____
IMPORTANT: If this is a Limited Healthcare (LFSA) - ONLY submit claims for Dental and/or Vision Expenses.		(REQUIRED)

DEPENDENT CARE (Daycare) – FLEXIBLE SPENDING ACCOUNT (FSA)

The following information is REQUIRED: Tax ID (or SSN) & Business Name; dates of service and the expense amount; either a receipt/bill OR your Provider's Signature below. NOTE: Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

DATE RANGE OF SERVICES	From / / through / /	TOTAL Dependent Care Reimbursement Request
PROVIDER'S TAX ID (or SSN)	**PROVIDER'S BUSINESS or NAME**	$ _____
Dependent Care Provider's Signature:	**Date** / /	(REQUIRED)

CLAIM CERTIFICATION

I certify these expenses for which reimbursement is requested on my Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) & are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return.

Signature	Date / /

SEND THIS FORM & A COPY OF RECEIPTS TO CHARD SNYDER (DO NOT SEND ORGINAL RECEIPTS)

Please submit this form with your required documentation to Chard Snyder via one of the three methods listed to the right…

- ☑ **Fax to:** Local (513) 459-9947 / Toll-Free (888) 245-8452 ***(Please DO NOT include a Fax Cover Page)***
- ☑ **Mail to:** 3510 Irwin Simpson Rd, Mason, OH 45040
- ☑ **Email to:** askpenny@chard-snyder.com

Flexible Spending Account
Claim Reimbursement Instructions

1. Complete all Company & Employee information on the front page (please print/type). NOTE: Please include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is processed and when a reimbursement is approved for you to receive payment.

2. Attach supporting documentation. Receipts must accompany this request form in order for claims to be considered for reimbursement. Be sure to keep your original receipts, bills, etc. for your records. Originals, if sent, will be destroyed. **All requests must include the following items to be eligible for reimbursement.** ***** DO NOT Highlight ANY PART of your Receipt ******

   - ☑ Original date of service (not the date of payment)
   - ☑ Description of service performed (refer to list of eligible expenses to identify valid services)
   - ☑ Provider's name**,** address & Tax ID/SSN (If submitting receipts for Dependent Care expenses.)
   - ☑ Amount charged to you (do not include amounts reimbursed by another source)

3. **Health Care – Flexible Spending Account Reimbursement Request:** Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as described above. ***Important****: If participating in a Limited Healthcare (LFSA), claims submitted can only be for dental and/or vision expenses*.

4. **Dependent Care (Daycare) – Flexible Spending Account Reimbursement Request:** Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as described above.

5. **It is REQUIRED that you Sign & Date** the '**CLAIM CERTIFICATION'** section on the front of this page.

6. **Fax, Mail or Email** this form and supporting documentation directly to **Chard Snyder**:

   - ☑ **Fax to:** Local (513) 459-9947 / Toll-Free (888) 245-8452 **(*Please DO NOT include a Fax Cover Page*)**
   - ☑ **Mail to:** 3510 Irwin Simpson Rd, Mason, OH 45040
   - ☑ **Email to:** askpenny@chard-snyder.com

7. If you have questions please contact us…

   - ☑ **Call Customer Service:** Local Phone: (513) 459-9997 / Toll-Free Phone: (800) 982-7715
   - ☑ **Visit our Website:** www.chard-snyder.com
   - ☑ **Email your questions to:** askpenny@chard-snyder.com

8. **Important Reminders:**

   - ☑ All requests are saved as electronic images. To ensure your claim is processed as soon as possible, and to avoid delays, please review the following recommendations:
     - ☑ Do NOT use a Fax Cover Page when faxing.
     - ☑ Do NOT Highlight any part of your receipts, bills, etc…
     - ☑ Only send copies of receipts, bills, etc… (Keep your originals)
     - ☑ Multiple receipts should be totaled on one claim form.
   - ☑ Payments are issued after receipt and processing, subject to claim approval. **Transfer between accounts is prohibited.**
   - ☑ Any items for which you are reimbursed **cannot be claimed again** as deductions or credits on your individual tax return at the end of the tax year.
   - ☑ If a **Dependent Care** claim is submitted for an amount that is larger than the amount credited to your account, payments will be issued according to the amount available. Anything requested above the available amount will "backlog" and will be released as additional credits are made to your account. ***IRS Guidelines*** *prohibit the advancement of Dependent Care reimbursements*.
   - ☑ You may only be reimbursed for eligible expenses incurred **during** the current plan year. ***Note: Orthodontia expenses are reimbursed as designated by the provider*.**
   - ☑ Payment will be made to you (participant only). **Payments cannot** be made to **alternate payee.**