Flexible Spending Account (FSA) Claim Form

NOTE: If you submit your claim online at www.asiflex.com, this form is not needed.

Your Name (Last, First, MI)	Social Security No. or EID or PIN	Your Employer Name
Doe, John	123-45-6789	ABC Inc

Address	City	State	Zip Code
123 Main Street	Any Town	Any State	00234-5678

Dependent Care Flexible Spending Account Claims

Payment is allowed only for services **that have already been provided and not for services to be provided in the future.** You may submit for a full month **after** the month has ended or submit for the **previous** week's expenses. To substantiate your claim, submit an itemized statement from your provider or **simply have your provider(s) sign below to certify* the care was provided.** If your provider signs below, no other supporting documentation is required. Expenses must be incurred to allow you, and if married your spouse, to work; and must be for the care and well-being of the dependent. Expenses for overnight camp, lessons or classes to learn a specific skill or sport, educational sessions or classes are not eligible.

Name of Dependent	Age	Dates Care Was Provided No Future Dates MM/DD/YY thru MM/DD/YY	①Name/Address of Care Provider or Care Facility ②Type of Dependent Care Service (Daycare, Day Camp, Preschool, After School Care, etc.)	Amount Requested
			①	$
			②	
			①	$
			②	
			①	$
			②	
			Total	**$**

* Day Care Provider or Care Facility Certification:	* Day Care Provider or Care Facility Certification:
I certify that I provided dependent care services as detailed above.	**I certify that I provided dependent care services as detailed above.**
Print Name:_____	Print Name: _____
Original Signature: _____	Original Signature:_____
Date: _____	Date:_____

Health Care Flexible Spending Account Claims

Follow the instruction page "How to File Claims" and submit correct documentation to assure rapid claim processing!

Date(s) of Service	Health Care Provider	Type of Expense (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship to You	Amount Requested
1/20/2017	Millard Hills Dental	Dental Checkup-20 miles	Self	Self	$ 3.60
2/17/2017	Lakeside Hospital	Lab Work-35 mile	Tim	Spouse	$ 6.30
3/17/2017	Hy-Vee Pharmacy	Rx-16 miles	Self	Self	$ 2.88
4/20/2017	Orthopedic Specialists	Consultation-98 miles	Tim	Spouse	$17.64
				Total	**$30.42**

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's FSA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify any claimed Dependent Care expenses are work-related to allow me and, if married, my spouse to work, are primarily for the protection and well-being of my dependent and were provided for my dependent under the age of 13 or for my dependent who is incapable of self-care. I certify that any claimed Dependent Care expenses are not for overnight camp, lessons or classes to learn a specific skill or sport, or for educational sessions or classes. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation. Claims are not accepted by email due to privacy/security concerns.

✔ Employee Signature_____ Date_____

FAX TO: 1-877-879-9038
PAGE_____OF _____
NO COVER PAGE REQUIRED

MAIL TO: ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

FILE ONLINE: WWW.ASIFLEX.COM
NO CLAIM FORM NEEDED!
REV 10/2016