SIHO INSURANCE SERVICES

Flex Spending Account Claim Form

Number of pages faxed ☐

SIHO Insurance Services
PO Box 628, Columbus, IN 47202
FAX: Toll free (800) 391-3539 or (317) 818-7922
PHONE: Toll free (888) 893-7440 or (317) 816-5179
Forms can also be emailed to: flex.info@siho.org

SECTION A – EMPLOYEE INFORMATION **Employer**

Employee Last Name (Please print)	**First Name**	**Middle Initial**
Social Security Number (Last 4 digits are sufficient)	**Check Box If Address Is New** ☐	
Employee Address	**City, State, Zip Code**	
Employee Email	**Daytime Phone**	

Please send photocopies of forms and documents. Keep originals for your records, as claims and supporting documentation become part of this claim and cannot be returned to you.

SECTION B – EXPENSES TO BE SUBMITTED

If you are submitting a Flex Debit Card receipt, check the "Debit Card Receipt" box and enter the amount in the "Net Amount" column. Attach copies of supporting documentation from your third party provider describing the service(s), for whom the service(s) were rendered, date(s) of service(s), and amount paid (such as all invoices, receipts, or other supporting documentation). The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, credit card receipts or statements are NOT acceptable forms of documentation for expenses. For Dependent Day Care, supporting documentation must indicate the tax ID number or social security number of the day care provider. **Effective 01/01/11, over-the-counter medicines and drugs except insulin must be accompanied by a prescription in order to be considered for reimbursement under the plan.**

Expense Type (Please Select One)			**Name of Service Provider** (Example: ABC Day Care, CVS, Dr. Jones, Wal-Mart Vision)	**Expense Description** (Dental, Medical, OTC, RX, Vision)	**Person For Whom Expense Was Incurred** (Spouse, Child, Tax Dependent)	**Non-Qualified Amount** (Debit Card Receipts Only - If applicable)	**Net Amount** (Debit Card Receipts Only)	**Date of Service**		**Amount of Expense** (Reimbursement Only)
Debit Card Receipt	**Health Care**	**Day Care**						**From**	**To**	
☐	☐	☐								
☐	☐	☐								
☐	☐	☐								
☐	☐	☐								
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☐	☐	☐								
☐	☐	☐								

Attach a receipt from your day care provider, or have the day care provider sign below.

TOTAL Amount To Be Reimbursed $_____

➔ **Day Care Provider's Signature** _____
(For Day Care Claims Only) I certify that the day care expenses shown are valid

SECTION C - EMPLOYEE CERTIFICATION

Read Carefully: I understand that if I am requesting substantiation for a Flex Debit Card payment or for reimbursement of expenses itemized above, I certify that the expenses for which reimbursement is requested under the reimbursement account were for services received by myself or my eligible dependent on the dates indicated and these are my out-of-pocket expenses that qualify as valid expenses under the plan and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan. If this claim is for medical expenses: I understand that if I, my spouse or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a limited purpose or post deductible medical reimbursement account (Health FSA) or a limited purpose, post deductible, suspended or retirement Health Reimbursement Arrangement (HRA). The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense.

SIGN AND DATE FORM ➔

I certify this claim in accordance with Section C – Employee Certification. Unsigned claims will automatically be denied.

PARTICIPANT SIGNATURE _____ **DATE** _____

To view your flex account visit www.ezflexplan.com/siho