CHARDSNYDER™
Benefit Solutions

East End Health Plan

Flexible Spending Account (FSA)
Claim Reimbursement Request Form

COMPANY INFORMATION (PLEASE PRINT)

Company Name	Division (if applicable)

PARTICIPANT INFORMATION (PLEASE PRINT)

Last Name		Primary Phone ( ) -
First Name		Secondary Phone ( ) -
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy) / /	Email Address (For Account Notifications)
Street Address (Check if New Address ☐)		
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 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 Flexible Spending Account - Submit claims only for dental and/or vision expenses		(REQUIRED)

DEPENDENT DAYCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

The following information is REQUIRED: Business name; dates of service and the expense amount; either a receipt/bill OR your provider's signature below. NOTE: Cancelled checks are acceptable for daycare expenses only; credit card statements/receipts are NOT sufficient proof of your claim.

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

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) and are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return.

Participant Signature (Required)	Date / /

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

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

- ☑ **Fax:** Local 513.459.9947 / Toll-Free 888.245.8452 ***(Please DO NOT include a Fax Cover Page)***
- ☑ **Mail:** 3510 Irwin Simpson Rd, Mason, OH 45040
- ☑ **Email:** askpenny@chard-snyder.com