# GROUP INSURANCE SERVICE CENTER, INC.

P.O. BOX 9120 • MARSHFIELD, MA 02050-9120

(800) 242-3834 In State • (800) 242-4472 Nationwide

# FLEXIBLE SPENDING PLAN CLAIM FORM

**EMPLOYEE INFORMATION - PLEASE PRINT NEATLY**

EMPLOYER NAME

| EMPLOYEE NAME | EMPLOYEE SOCIAL SECURITY NO. |
|---|---|

EMPLOYEE'S ADDRESS   STREET   CITY   STATE   ZIP CODE

| DEPENDENT NAME (First, Middle Initial, Last) | SOCIAL SECURITY # | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |

**SUMMARY OF ATTACHED CHARGES - BILLS MUST INCLUDE ADRESS AND TELEPHONE NUMBER OF PROVIDER**

| DATES OF SERVICE | | NAME OF PROVIDER | PERSON RECEIVING SERVICE | AMOUNT OF BILL | DESCRIPTION OF SERVICES RECEIVED | √ HEALTH CARE | √ DEPEND CARE |
|---|---|---|---|---|---|---|---|
| FROM | TO | | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| | | | TOTAL BILLS ➡ | | | | |

DOCUMENTATION

Submit the following documentation with this form:

EITHER:

Health Care - Itemized bills indicating name of provider, type of service or description of items purchased, date services provided or supplies purchased and amount charged.

OR:

- Explanation of Benefits when expenses not fully reimbursed by another benefit plan.

- Orthodontia claims also require a statement of total charges from dentist and a copy of each payment statement from your insurance carrier.

Dependent Care - Business receipt or signed statement from the provider of the service identifying type of service, service period, recipient of service and the amount charged.

**EMPLOYEE'S STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION**

I certify that information furnished by me in support of this claim is true and correct. I understand that such information is subject to verification and the audit procedures of the Company. I also understand that claims without proper documentation will not be reimbursed.

I also certify that the expenses 1) have been incurred on or during the dates indicated and have been or will be paid; 2) are eligible for reimbursement under the plan as described in the Summary Plan Description or the Internal Revenue Code; 3) have not previously been reimbursed by and will not be reimbursed again by this or any other plan or insurance policy; and 4) will not be deducted or claimed for credit for income tax purposes.

Signature ______________________ Date signed ____________