

# Flexible Benefit Plan Claim Form

**To expedite your claim:**

- Provide *all* appropriate information.
- Review the Total Medical Care Expense amounts

Employer:

Employee Name:

Social Security Number:

Phone:

E-mail:

## Flexible Spending Account Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
<b>➡ Attach appropriate receipt(s) and submit with this claim form.</b>			<b>Total Expense Claim</b>	<b>\$</b>

**Read Carefully:** The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Spending Account Arrangement (FSA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. 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 which is provided by the undersigned, 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.

Your Flexible Spending Account Arrangement (FSA) Plan may be limited by the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your FSA Plan for a list of eligible expenses.

Employee's Signature

Date

Mail Claim Form and Receipts to:  
 Home/Guest Insurance Agency  
 FSA/HRA Dept  
 1012 eWall Street  
 Mt. Pleasant, SC 29464  
 or Fax to 843-375-0157

# Claim Form & Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. **The receipt must show the date and type of service for the expense.** Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

If you choose to **mail** your claim with receipts, the address is Flex Claims Group, Horne/Guest Insurance Agency., 1012 eWall Street, Mt. Pleasant, SC 29464 (*Please remember to keep a copy of the claim form and supporting documents for your records.*)

If you choose to **fax** your claim with receipts, the fax number is 843-375-0157 After you fax a claim and receipts, please **do not** follow-up with a hard copy in the mail. (*Remember to keep the original claim form and supporting documents for your records.*)

To **verify** that your claim has been received, please go to the Web site described below. When your claim is approved, it will appear within three business days on the Web site under “view account.”.

You may check your **account balance status** any time, day or night at the Web site. In addition, the Web site has a claim form, a list of qualifying expenses, and other administrative tools that will help you conveniently manage your account. The site also has frequently asked questions and instructions on how to contact us. The Web site address is [www.ezflexplan.com/hg](http://www.ezflexplan.com/hg)

---

## ***The EzFSA Web site has everything you need to manage your Account...***

- > Verify your election
- > View your account balance
- > Print blank claim forms
- > How and where to file claims
- > Look up qualified expenses
- > Change in status rules
- > Change your address or other person information
- > Eligibility requirements
- > Calculate your tax savings
- > Learn about the plan
- > How to contact us

---

*Copy the front and back of this claim form for future use*

---