FLEXIBLE SPENDING ACCOUNT

MEDICAL REIMBURSEMENT ACCOUNT CLAIM FORM

COMPANY NAME: ____

EMPLOYEE NAME: __________________________________

ID NUMBER: _____–_____–_____

ADDRESS: ______________________________________

____

PHONE NUMBER: __________________________________

E-MAIL ADDRESS: __________________________________

SEND CLAIMS TO:
Group Administrators, Ltd.
Attention: FSA Administration
20 North Martingale Rd., Suite 290
Schaumburg, Illinois 60173

Email:fsa@groupadministrators.com
Telephone: (847) 519-1880
Fax: (855)-978-2331

____ **Check if Name Change** ____ **Check if Address Change**

EXPENSES TO BE REIMBURSED: (Please Itemize)

Date Medical Service Actually Provided	Provider Name or Facility of Service	Patient Name/ Relationship	Total Expense	Amount Paid by Insurance or Other Plan	Reimbursement Requested
1.			$	$	$
2.			$	$	$
3.			$	$	$
4.			$	$	$
5.			$	$	$
6.			$	$	$
				Total Requested	$

********The following section MUST be completed by the employee.********

EMPLOYEE CERTIFICATIONS & REQUIREMENTS FOR REIMBURSEMENT:

_____ I have insurance coverage through a group or private plan and my explanation of benefits or denial(s) is enclosed indicating what insurance is not paying. **THIS INFORMATION MUST BE INCLUDED IF YOU HAVE ANY INSURANCE COVERAGE**. ***Canceled checks or balance due receipts are not acceptable.***

_____ I am covered by an HMO Plan and my itemized paid receipts are attached for just my co-pay amount.

_____ I am covered by a PPO or POS Plan. I have attached my itemized paid receipt for the co-pay amount(s) or I have attached my EOB for charges above the co-pay amount.

_____ I have no insurance coverage, at all, for the above expense(s). I have attached the itemized bill and paid receipt. (i.e. vision)

_____ Orthodontia Expenses. I have included my itemized paid receipt. If I have Orthodontia Insurance I have also included my most recent explanation of benefits.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the extent I am reimbursed from my Spending Account.

SIGNATURE: ______________________________________ **DATE:** _____/_____/_____

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Group Administrators to initiate automatic deposits to my account at the financial institution named below. I also authorize Group Administrators to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Group Administrators responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Group Administrators receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Employee Information

Employee Name: ______________________________

Social Security Number or Alternate ID:

Account Information

Name of Financial Institution: ____________________ ☐ Checking | ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature

Authorized Signature: ______________________________ Date: __________

Please attach a voided check.