HealthPlans, Inc.

Claim Form — Flexible Spending Account

Use this form to submit for reimbursement of eligible medical, dental, vision and dependent care expenses.

Employer/Company Name	*Department/Division*	*Health Plans Member ID# and/or Employee SSN*

Employee Last Name	*First Name (Subscriber)*	*MI*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*

Email Address	*Primary Phone#*	*Alternate Phone#*

Instructions

For reimbursable expenses that were part of a medical or dental claim, attach copies of insurance plan claim and/or payment forms (to establish amounts not paid under the insurance plan). For all other reimbursable expenses (including Dependent Care expenses if you have enrolled in that option), attach copies of all invoices/receipts, which must include the following:

- the date(s) of service
- the name and address of the service/product provider
- a description of the expense *(i.e., the nature of the service/ product; include the product name, quantity/size if applicable*)
- the name and Social Security Number of the member who received the services/product
- the amount of the charges

Date of Service *(MM/DD/YYYY)*	Name & Address of Service/Product Provider	Describe Expense	Member Name	Member SSN	Net Amount
					$
					$
					$
					$
					$
					$
					$
					$
					$

CLAIM TOTAL $

Please Read Carefully

The undersigned Plan Participant (Subscriber) certifies that all expenses claimed herein were incurred during a period of active coverage. The undersigned understands that he or she is fully responsible for the sufficiency, accuracy and veracity of all information contained herein, and that if an expense claimed herein is not an eligible expense under the plan, the undersigned may be liable for the payment of all related taxes (including federal, state or city income tax) on amounts paid by the plan which relate to said expense.

I certify that all items claimed herein comply with the Flexible Spending Account program, and said items have not and will not be covered by any other plan or program of any employer, or other party, and will not be reimbursed through a rebate program.

Signature: _____ _____

Signature of Employee *Date Signed*

Print and submit this form to:

Health Plans, Inc.
Attn: Flexible Spending Dept.
PO Box 5199
Westborough, MA 01581

or fax to: 508-329-4815

Please retain a copy of this form and all related documentation for your records.

*Questions? Please call **877-734-7004**, or submit your question online at **HealthPlansInc.com**; just click on **Contact**.*