Please send this form along with all applicable receipts to:
1200 River Ave, Suite 10E, Lakewood, NJ 08701
Fax: 877-747-8564
E-Mail: Claims@flexfacts.com

FSA Spending Account Claim Form

Personal Information

Full Name: _____
Last *First* *M.I.*

Employer: _____

Last Four Digits of Your Social Security Number _____

Phone: **( )** _____ E-mail: _____

If your address has changed please list the new address below.

New Address: _____

City, State, Zip _____

FSA Claim Information

Please enter in Medical FSA as the "Type of Expense" below.

Type and Date of Expense: _____ Amount: _____

Type and Date of Expense: _____ Amount: _____

Type and Date of Expense: _____ Amount: _____

Type and Date of Expense: _____ Amount: _____

Type and Date of Expense: _____ Amount: _____

Type and Date of Expense: _____ Amount: _____

Employee Signature: _____

Date: _____

- By signing this form, I agree to have my account reduced by the amount requested.
- This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- If additional information is required you will receive a denial email letting you know what additional information is needed.
- Claims incurred during a grace period will be paid out of the prior year first.
- Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact your employer to see if advance payments for orthodontia expenses are allowed.