Claim for Health FSA Reimbursement

Employer/Plan Sponsor Name **Washington College**

Employee Name:_____ **SS#: _____**

Please remember to sign this form below and provide receipts for each reimbursement request. Thank you.

This claim form is to be used only to request reimbursement from your Health FSA for unreimbursed medical expenses. Please complete this claim form and attach the itemized bill, insurance EOB, or other proof of expense. Receipts, cancelled checks or credit card receipts can not be accepted.

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
				$
				$
				$
				$
				$
				$

Total Medical Care Expense Claim $_____

READ CAREFULLY
The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed and will not be submitted for reimbursement under any other health plan coverage. The undersigned 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.

_____

Employee Signature Date Daytime Phone Number

If you have any questions please contact Innovative Health Services at 410-763-8787 or 888-769-8787, ext. 101 or 100.

Innovative Health Services PO Box 778 Easton, MD 21601 FAX 410-763-8788