



FLEXIBLE SPENDING ACCOUNT (FSA) REQUEST FOR REIMBURSEMENT

Please Include the following:

1. Completed AmeraPlan form.
2. Itemized receipts and/or EOB
3. Mail form and receipts to AmeraPlan, Inc.: 3001 West Big Beaver Road, Suite 320, Troy, MI, 48084

CLAIM WILL BE DENIED IF FORM IS NOT COMPLETE, INCLUDING PROPER CERTIFICATION & APPROPRIATE DOCUMENTATION.

COMPANY INFORMATION:				
Company Name:		Employee's SSN/AmeraPlan ID Card Number:		
Last name:		First Name:		M.I.
Street Address:		Home Phone Number:		
City:		State:		Zip:

HEALTH CARE REIMBURSEMENT:				
Date Expense Incurred	Patient Name	Name of Service Provider	Expense Description	\$ Amount
Month/ Date /Year / /				
/ /				
/ /				
/ /				
<input type="checkbox"/> Additional Claim Forms Attached. TOTAL:				\$

HEALTHCARE CERTIFICATION:

Will your insurance carrier(s) be processing a claim for any of these charges? If "YES," please attach a copy of the EOB from the insurance carrier for documentation. For expenses not covered by insurance, submit an itemized receipt or statement of purchase from the provider. This should show the date of service, provider's name and address, and a description of the procedure & charges incurred.

YES
 NO

DEPENDENT CARE EXPENSES:			
Date Expense Incurred	Name of Service Provider	Tax ID/SSN	\$ Amount
From: / / To: / /			
From: / / To: / /			
<input type="checkbox"/> Additional Claim Forms Attached. TOTAL:			\$

DEPENDENT CARE PROVIDER CERTIFICATION: (Necessary only if receipt is not provided)

Signature: _____ Date: _____

I certify that the services, for the above noted service period(s), and cost(s) have been incurred by the claimant, and that I have not previously certified these specific expenses.

I request reimbursement for the expenses listed above. I am including a receipt or other appropriate third party proof of incurred expenses during the plan year, and during a period while the undersigned was covered under this plan. I have not been reimbursed for these expenses under our insurance plan or under any other source.

In addition, the total amount claimed for dependent care does not exceed the lesser of my spouse's expected income for the year (special maximums and conditions may apply if your spouse is a student or is handicapped, and has no other income).

I understand that I cannot claim these expenses on my personal income tax return, since I have already received a tax advantage on these amounts via the Section 125 Plan.

Employee Signature:	Date:
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Customer Service: 800.221.4254 - Fax: 248.643.9401

FSA Account Balances are available, under the Claimant Portal, at www.ameraplan.com