

**Health flexible spending account claim status and account balance can be viewed at [www.significabenefits.com](http://www.significabenefits.com)**

## HEALTH FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Sign, date, and submit the original Claim Form and copies of attachments to SBS. Keep a copy of the submission for your records.

**Significa Benefit Services, Inc. (SBS)**  
**P.O. Box 7777**  
**Lancaster, PA 17604-7777**  
**Phone: 717.581.1300 or 800.433.3746**  
**Fax: 717.581.8379**

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SS Number/Member Number: \_\_\_\_\_

Daytime Telephone Number (including area code): \_\_\_\_\_ E-mail Address: \_\_\_\_\_

### UNREIMBURSED MEDICAL EXPENSE CLAIMS

Complete this section to be reimbursed for eligible expenses incurred during the plan year while you were a participant. An expense covered under another benefit plan (including your spouse's benefit plan) cannot be reimbursed under the flexible spending account plan. An expense covered under another benefit plan must be submitted there first. That plan will provide you with an Explanation of Benefits (EOB) explaining if and to what extent the plan reimbursed the expense you submitted.

Instructions	Date of Service	Name of Patient	Name of Provider	Name of Drug or Type of Service	Amount Charged
An expense is incurred when the service is provided, not when you are billed or paid for the service.					
<ul style="list-style-type: none"> <li>• <b>To prevent processing delays, complete all boxes and attach required documentation for each expense claimed, as follows:</b> <ul style="list-style-type: none"> <li>○ For an expense covered under another benefit plan (including your spouse's benefit plan): provide the EOB.</li> <li>○ For an expense not covered under another benefit plan (including your spouse's benefit plan): provide an itemized bill.                             <ul style="list-style-type: none"> <li>▪ The itemized bill must include – the provider's name and address, patient's name, date of service, type of service, and the amount charged for the service.</li> <li>▪ However –                                     <ul style="list-style-type: none"> <li>• For a prescription drug/supply expense, the itemized bill must include – the pharmacy's name and address, patient's name, date of service, description of item, prescribing physician's name, and the amount charged.</li> <li>• For an over-the-counter drug/medical supply expense (if eligible for reimbursement under your employer's plan), a cash register receipt showing the drug name, date of service, and price will be sufficient.</li> </ul> </li> </ul> </li> </ul> </li> <li>• <b>Canceled checks presented without other required documentation are not acceptable receipts.</b></li> </ul>	<input type="checkbox"/> <b>Apply to Current Year</b> <input type="checkbox"/> <b>Apply to Last Year</b>				\$
					\$
					\$
					\$
					\$
					\$
					\$
	<b>Total Unreimbursed Medical Expenses</b> (Use additional pages if needed. Expenses must be totaled on each page.)				

### Employee Certification

I hereby certify that all items requested to be reimbursed:

- were incurred for services or supplies received by myself or my eligible dependents;
- comply with my employer's flexible spending account plan;
- have not and will not be covered by any other plan or program of any employer or other person; and
- have not been deducted or will not be deducted on my individual income tax returns.

I authorize my health care flexible spending account to be reduced by the amount requested.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Dependent care flexible spending account claim status can be viewed at [www.significabenefits.com](http://www.significabenefits.com)*

## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Sign, date, and submit the original Claim Form and copies of attachments to SBS.  
Keep a copy of the submission for your records.

**Significa Benefit Services, Inc. (SBS)**  
P.O. Box 7777  
Lancaster, PA 17604-7777

**Phone: 717.581.1300 or 800.433.3746**  
**Fax: 717.581.8379**

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SS Number/MemberNumber: \_\_\_\_\_

Daytime Telephone Number (including area code): \_\_\_\_\_ E-mail Address: \_\_\_\_\_

### DEPENDENT CARE EXPENSE CLAIMS

Complete this section to be reimbursed for eligible expenses incurred any time during the same plan year in which you were a participant. An expense covered under another benefit plan cannot be reimbursed under the Flexible Spending Accounts Plan.

	Date of Service	Name of Dependent	Name, Address, and Federal I.D. or Social Security Number of Provider of Service	Amount Charged
<b>Instructions</b>	An expense is incurred when the service is provided, not when you are billed or paid for the service.			
	<input type="checkbox"/> Apply to Current Year		<input type="checkbox"/> Apply to Last Year	
<ul style="list-style-type: none"> <li>• To prevent processing delays, complete all boxes and attach a copy of the receipt for each expense claimed.               <ul style="list-style-type: none"> <li>○ The receipt must include – the date(s) of service, name of the dependent, provider's name, address, and Federal I.D. or Social Security Number, and the amount charged for the service.</li> </ul> </li> <li>• Canceled checks presented without other required documentation are not acceptable receipts.</li> </ul>	From			\$
	To			
	From:			\$
	To:			
	From:			\$
	To:			
	From:			\$
To:				
<b>Total Dependent Care Expenses</b> (Use additional pages if needed. Expenses must be totaled on each page.)				\$

#### Employee Certification

I hereby certify that all items requested to be reimbursed:

- are for the care of qualifying individuals;
- comply with my employer's flexible spending account plan;
- have not and will not be covered by any other plan or program of any employer or other person; and
- will not be deducted or taken as tax credits on my individual income tax returns.

I authorize my dependent care flexible spending account to be reduced by the amount requested.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_