



FSADirect REQUEST FOR MEDICAL REIMBURSEMENT
PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

ACCOUNT HOLDER GENERAL INFORMATION

Group: Plan ID:

Partic. ID# If this is a new address check here

Name Last First

Address

City State Zip -

Phone () - - E-Mail

IMPORTANT INSTRUCTIONS:

- You **must** attach an itemized bill or explanation of benefits (EOB) form for healthcare expenses. **Do not** attach checks or credit card slips as you may be required to provide additional documentation.
- Expenses that **CAN NOT** be reimbursed include cosmetic expenses, insurance premiums, and general wellness expenses.
- Fax the claim to 1-800-726-9982 or 704-335-0818 in the Charlotte area.

Or mail to: Flores & Associates • P.O. Box 31397 • Charlotte, NC 28231-1397

Claim Submission Deadline:

You have until the above day after the end of the plan year to submit claims for the previous plan year.

Customer Service: 1-800-532-3327

REIMBURSEMENT REQUEST DETAIL

Please complete one section for each included receipt and total at the bottom. Use additional forms as needed.

Date Of Service (not payment date) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
Patient Name <input type="text"/>	Name Of Provider <input type="text"/>	
Date Of Service (not payment date) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
Patient Name <input type="text"/>	Name Of Provider <input type="text"/>	
Date Of Service (not payment date) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
Patient Name <input type="text"/>	Name Of Provider <input type="text"/>	
Date Of Service (not payment date) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
Patient Name <input type="text"/>	Name Of Provider <input type="text"/>	

SERVICE CODE KEY			
01 - Medical	03 - Vision	05 - Mileage	07 - Other
02 - Dental	04 - Prescription	06 - Orthodontia	08 Over The Counter

Total Requested For This Page

REIMBURSEMENT AUTHORIZATION

I certify that I have not previously requested reimbursement for the above expenses under this or any other plan and I am not able to receive additional insurance benefits or reimbursements from any other source for these expenses. I certify that these expenses are eligible for reimbursement in accordance with the Flexible Spending Account SPD provided by my employer. I further certify that these expenses are for eligible dependents as defined under Internal Revenue Code Section 152.

Participant Signature (Void if not signed)

Date Signed





FSADirect NO-WAIT DEPENDENT CARE REIMBURSEMENT

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

GENERAL INFORMATION

Group: Plan ID:

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Name Last First

Address

City State Zip -

Phone () - - E-Mail

Important: You must attach receipts from your dependent care provider or have your provider sign in the appropriate block next to the detail item. Do not attach checks or credit card slips as the IRS does not recognize these as valid receipts for this program.

Fax the completed form to 800-726-9982 or 704-335-0818 in the Charlotte area.
Or mail the completed form to: Claims Processing- P.O. Box 31397- Charlotte, NC 28231-1397

Claim Submission Deadline:

You have until the above day after the end of the plan year to submit claims for the previous

REIMBURSEMENT REQUEST DETAIL

Please complete one section for each included receipt and total at the bottom. Use additional forms as needed.

Service Date From:	Service Date To:	Dependent	Cost
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Provider		<input type="text"/>	
Tax ID#:		<input type="text"/>	
Provider Signature (Required If Receipt Not Attached)			
Service Date From:	Service Date To:	Dependent	Cost
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Provider		<input type="text"/>	
Tax ID#:		<input type="text"/>	
Provider Signature (Required If Receipt Not Attached)			
Service Date From:	Service Date To:	Dependent	Cost
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Provider		<input type="text"/>	
Tax ID#:		<input type="text"/>	
Provider Signature (Required If Receipt Not Attached)			
Service Date From:	Service Date To:	Dependent	Cost
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Provider		<input type="text"/>	
Tax ID#:		<input type="text"/>	
Provider Signature (Required If Receipt Not Attached)			
Service Date From:	Service Date To:	Dependent	Cost
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Provider		<input type="text"/>	
Tax ID#:		<input type="text"/>	
Provider Signature (Required If Receipt Not Attached)			
			Total <input type="text"/>

REIMBURSEMENT AUTHORIZATION

I understand that dependent care expenses reimbursed under this plan can not be claimed as a deduction on my personal income tax return. I acknowledge that neither the group nor Flores & Associates, LLC(1) is independently verifying that the dependent care providers I select comply with state and local laws applicable to them, (2) has any responsibility for or obligations relating to the dependent care services rendered by any dependent care provider or any of its employees or representatives and (3) is making any commitment or guarantee that any money which is deducted from my pay (salary) is excludable from my gross income for federal, state or local income tax purposes. I also understand that it is my obligation to determine whether the amount deducted from my pay is excludable from my gross income and to notify the group if I have reason to believe any such payment is not so excludable. I agree to hold the group and Flores & Associates, LLC harmless from any and all liability and costs which either or both may incur as a result of, or in connection with, the provisions of dependent care service to me or on my behalf by any dependent care provider.

Participant Signature (Void if not signed)

Date Signed





FSADirect DIRECT DEPOSIT INFORMATION
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GENERAL INFORMATION

Group: Plan ID:

Partic. ID#

Name Last First

Address

City State Zip -

E-Mail Check here if this is a new address

Fax the completed form to 800-726-9982 or 704-335-0818 in the Charlotte area.
Or mail the completed form to: Claims Processing • P.O. Box 31397 • Charlotte, NC 28231-1397

BANKING INFORMATION

Contact your financial institution to obtain the information requested below.

- Begin Direct Deposits Change Existing Information Cancel Direct Deposits

Bank Name

Bank City

Bank State

Bank Phone # - -

Routing#

Account#

Type of Account Checking Savings

DIRECT DEPOSIT AUTHORIZATION

I hereby authorize FLORES & ASSOCIATES, LLC to deposit any amounts owed me by initiating credits to my account at the financial institution (hereinafter BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by FLORES & ASSOCIATES, LLC to my account. In the event that FLORES & ASSOCIATES, LLC deposits funds erroneously into my account, I authorize FLORES & ASSOCIATES, LLC to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until FLORES & ASSOCIATES, LLC and BANK have received written notice from me of its termination in such time and in such manner as to afford FLORES & ASSOCIATES, LLC and BANK a reasonable opportunity to act on it.

Employee Signature (Void if not signed)

Date

