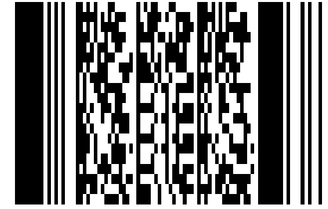

##15T01602####################

FSA Benefits Claims Form

Employer__________________
Employee__________________
SSN ______________________
Phone ____________________
E-mail ____________________

FSA Benefits Claims for Medical Purchases

Refer to the instructions below to completely fill out the following table. Please keep your receipt.

1 **Name of Person Receiving Medical Item or Service**	2 **Provider's Name (e.g., physician, hospital, pharmacy)**	3 **Purchase Date**	4 **Description of Item or Service**	5 **Price**
			6 **Total Medical Expenses**	$.
7 **Provider's Address**				
8 **Provider's Signature or Stamp (if receipt is unavailable)**				

Read carefully. Not fully completing this form could delay the processing of your claim.
You must have already received and purchased the items or services you list above before submitting a claim for reimbursement.

First, complete sections 1-7 in the table above. Then, either have your provider sign off on or stamp the information you've provided (row 8), send us an Explanation of Benefits (EOB), **OR** send us an easy-to-read receipt (you may send multiple) that includes the following details:

Your full name
The date you purchased the item or service
The name of the provider who offered the item or service
The cost of the item or service

The name of the item or service you received

Lastly, attach any receipts or EOBs to an email along with your completed claims form, and send it to claims@zenefits.com.

Credit card receipts alone aren't enough. If you don't send us all the information we need, processing your claim may take longer than expected. If one of your receipts shows an ineligible expense, reimbursement may be fully or partially denied.

Orthodontic Purchases

Orthodontic purchases—specific types of dentistry services—require that you send in different verifying documentation. For us to confirm orthodontic purchases as eligible expenses, you'll need to send us proof of payment (bills and credit card receipts are acceptable) **AND** a copy of your orthodontia contract along with this completed claims form.

Please sign and date this claims form to accept the terms below:

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

Employee Signature:	
:	

Email claims forms and receipts to **claims@zenefits.com**.
If you have any questions, contact support at support@zenefits.com or 1 (888) 249-3263.