

Flexible Spending Account Health Care Claim Form

Submit this form to: Employee Benefits Suite 100 Donhowe 319 15 th Ave. SE Minneapolis, MN 55455	U Wide Form UM 1506
	Rev: 11/05

Instructions: Complete all sections of this form. Remember to sign and date the form and to include your Employee ID. Return this form with photocopies of documentation of expenses (Explanation of Benefits statements from health plans, fully itemized bills, receipts, statements, etc., from providers) verifying dates and types of service. Canceled checks and credit card receipts are not acceptable forms of documentation. Documentation cannot be returned. If you have questions, call 612-624-9090, option 3, or 1-800-756-2363.

Reimbursement Process: If you are enrolled in payroll direct deposit, your reimbursement check will be deposited into the same bank account. Otherwise, checks will be mailed to your home address.

Employee Name (Last, First)		Day Phone		Employee ID
Street Address	City	State	Zip	These expenses have been incurred during calendar year:

	Dates of Service		Amount Claimed for Reimbursement	Description of Expense (e.g., medical/dental/drug copays, eyeglasses, etc.)	Person for Whom Service was Provided		
	From	To			Name	Date of Birth	Relationship to Employee
1							
2							
3							
4							
5							
Total:							

Employee Certification: I request payment from my health care Flexible Spending Account for the expenses listed above. I certify these expenses have been incurred by me or my eligible dependents and qualify for reimbursement (refer to the Flexible Spending Accounts booklet or <http://www.umn.edu/ohr/benefits/fsa/>); the expenses are not for general health or cosmetic purposes. I further certify that these expenses have not been and will not be reimbursed from another source.

Signature of Employee:	Date:
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Office Use Only

Approved by:	Date:	Verified by:	Date:
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