



*Health Design Plus does not insure benefits under the Plan. Your employer is solely responsible for determination of, entitlement to, and payment of, any amounts due under the plan.

Health Design Plus

Health Care Flexible Spending Account Claim

Employer: _____

To avoid processing delays please sign and fill out the form completely.

Employee Name: _____	Employee Identification Number: _____
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Employee's Mailing Address

Street Apt. # City State Zip Code

Health Care Expense

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from a doctor, dentist, pharmacy, or other supplier and the Explanation of Benefits (EOB) statement(s)) as well as proof that this will not be paid by anyone other than you. You will not be entitled to claim this expense as a tax deduction.

Date of Service	Provider of Service	Description of Expense	Expense incurred for Self, Spouse, or Dependent	Amount

Health Care Expense Total:

Health Care Flexible Spending Account Certification

I certify that the expenses for which I am seeking reimbursement have been incurred by me, or by an individual who qualifies as my spouse or my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Saving Account (H.S.A.) or Flexible Spending Card. I also certify that I have not, and will not claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns. I agree to submit sufficient documentation of any expense for which I seek reimbursement.

I understand if I knowingly, and with intent to defraud, file a statement of claim containing any materially false, incomplete or misleading information, I am guilty of a crime.

Employee Signature _____ **Date** _____

How to Request Health Care Flexible Spending Account Reimbursement

- Please fill out the Health Care Flexible Spending Account Claim form **completely** to avoid delay of reimbursement. Date and sign the Health Care Flexible Spending Account Claim form. The claim form will be returned if it is not completed, signed, or does not have the proper substantiating documentation attached.
- Please note that when coordination of benefits is involved in requesting reimbursement for health expenses, a copy of the other carrier's Explanation of Benefits must be attached.
- If you are uncertain whether an item is a qualified medical expense, refer to IRS Publication 502 at www.irs.gov or ask your tax consultant.
- You have the right to appeal any denial of a claim relating to your Health Care Flexible Spending Account in whole or in part. Please refer to your **Summary Plan Description** for details concerning your appeal rights and information on how to formally file an appeal. Contact Customer Service at the number on your group health card for any questions.
- You may submit claims for this account for 90 days after the plan year ends as long as the expense was incurred **before** the end of the plan year.

NOTE: If your plan designates a grace period, you may submit claims incurred for an additional 75 days after the end of the plan year. Any contributions left over at the end of the grace period will be forfeited.

Claims received by HDP will be processed using the first-in, first-out method. It is possible that claims for expenses in Plan Year 1 may be denied because Plan Year 2 claims for expenses incurred within the grace period were submitted first and processed (exhausting the available funds).

Mail Completed Form & Documentation to:

**Health Design Plus/ Flex Department
1755 Georgetown Road
Hudson, OH 44236**