



# Aflac Benefit Services Request for Reimbursement Form

Instructions: Please print or type the information below.

Aflac Benefit Services CLAIM FAX: 1.877.353.9256

- 1. Sign and date form.
- 2. The Total Dependent Care Reimbursement requested box **must be completed**.
- 3. The Medical Care Total requested box **must be completed**.
- 4. Receipts attached must be clear and legible.
- 5. Allow 48 business hours to check status of reimbursement request.
- 6. **Please maintain copies of all receipts for your records.**

**Employee Information**  Check here if address change

<b>Participant's Social Security Number (Optional)</b>		<b>Employer Name</b>	
<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Participant's E-Mail Address</b>
<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>ZIP</b>

By submitting this claim form, I request reimbursement from my FSA account(s) as listed below. I agree to the Terms and Conditions outlined in my employer's Summary Plan Description. I certify and warrant to Aflac that these are eligible medical and/or dependent care expenses that I or my dependents have incurred, are not cosmetic in nature, and cannot be reimbursed from any other source. I will maintain copies of all documentation for my records.

**Participant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Dependent Care Claim Information

**For Dependent Daycare expenses that allow you and your spouse, if applicable, to work. You may file your claim in one of the following ways:**

- OPTION 1** must include: **-OR-**  **OPTION 2** must include:
- 1. Date(s) of Service (only services received; no future dates).
  - 2. Reimbursement requested (This amt is = to or < than amt charged).
  - 3. Name and age of the dependent receiving care.
  - 4. Provider name, phone number and dated signature.

Name / Age of Dependent Receiving Care	Date(s) Services Were Provided	Amount Requested
/	____/____/____ - ____/____/____	
/	____/____/____ - ____/____/____	
/	____/____/____ - ____/____/____	

**Total Dependent Care Reimbursement Requested**

**\$** \_\_\_\_\_

**Dependent-Care Provider Business Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Medical Care FSA Claim Information

For **Medical Care expenses**, an Explanation of Benefits (EOB) from your insurance company or other receipt(s) must be submitted. **The EOB and/or attached bills must contain the following items in order to be processed and approved:**

- 1. Patient Name
- 2. Service Provider
- 3. Description of Service
- 4. Date(s) service was provided
- 5. Amount/Copay

List each receipt separately in the space(s) below. Use additional forms if necessary. A total must be indicated in the Total block below. Use the Provider Certification space below only if no receipt is attached. **Do not** indicate "see attached" in the spaces below.

FSA Card Receipt	Patient Name	Service Provider	Description of Service	Date Service Was Provided	Requested Amount
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

**TOTAL \$**  

### Provider Certification

In lieu of receipts or EOB(s) the provider of the service can certify that the above listed medical care expenses have been incurred and only incurred by either the participant or his/her dependents. Any other expenses must have receipts or a separate completed form. Failure to complete all items will result in an invalid claim request.

**Provider Name and Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**Provider's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

I certify that the Medical Care expenses listed above were incurred by the patient named above.

## Helpful Tips for Filing Your Claim

1. Complete, sign and date the FSA Request for Reimbursement Form. Failure to complete all areas will result in claim rejection and a delay in processing and reimbursement. Do not indicate "See Attached" in any field. Descriptions of service should provide as much detail as possible. If a provider certification is used, the provider must sign and date each new claim form.
2. Submit documentation that is clear and legible. Do not highlight information; these areas often turn black when scanned. In addition, double check to make sure all documentation is clearly visible and not overlapped, written through, or cut off if photocopied.
3. Verify that services received are eligible expenses. See below or refer to your *Participant Handbook* for general guidance.
4. The deadline or run-off period for claims submission is determined by your employer. For more information on the run-off period, refer to your employer or your Summary Plan Description. To avoid delays, submit your claims at least two weeks prior to the end of your run-off period.
5. Additional reimbursement forms can be obtained at [aflac.com](http://aflac.com) or via the IVR at 1-877-353-9487.

## Sample Health FSA Expenses

This list is not all-inclusive; for more detailed information, refer to the *Participant Handbook*. Unreimbursed medical expenses are reviewed according to the regulations of Internal Revenue Code Section 125. All claims must be substantiated, and appropriate documentation must be provided. *Some expenses may require additional documentation from your doctor or health care provider.*

### Insurance

#### Eligible

Deductibles, copayments, and coinsurance for medical care plans

#### Ineligible

All premiums/contributions for insurance  
Long-term care plans  
Expenses paid totally by your health plan

### Medical Equipment

#### Eligible

Wheelchairs/crutches  
Blood sugar monitors  
Oxygen equipment  
Hearing aids, batteries, or hearing aid repairs

#### Ineligible

Equipment replacement insurance and/or warranties  
Vacuum cleaners for individuals with dust allergies

### Vision Care

#### Eligible

Prescription eyeglasses  
Contact lenses and cleaning solution  
Prescription sunglasses

#### Ineligible

Lens replacement insurance/warranties  
Protection plans  
Coatings/tints not used to treat a medical condition

### Treatments/Therapies

#### Eligible

Prescribed weight loss programs to treat a medical condition (not including foods)  
Diagnostic services (e.g., X-ray and MRI treatments)  
Smoking cessation programs  
Fertility treatments

#### Ineligible

Illegal treatments  
Physical treatments for general well-being or relaxation (e.g., massage therapy)

### Dental/Orthodontic Care

#### Eligible

Routine exams, cleaning, and X-rays  
Artificial teeth/dentures  
Braces and orthodontic services

#### Ineligible

Teeth bleaching/whitening  
Tooth bonding that is not medically necessary (e.g., cosmetic veneers)

### Drugs

#### Eligible

Prescription drugs to treat a medical condition  
Birth control  
Insulin

#### Ineligible

Dietary supplements for general health, to include vitamins and herbs  
Drugs for cosmetic purposes, over-the-counter medicines, unless prescribed by a physician.

### Fees/Services

#### Eligible

Physician consultation fees  
Routine office visits  
Nursing services for care of a specific ailment  
Legal sterilization

#### Ineligible

Cosmetic procedures that improve appearance but do not meaningfully promote the proper function of the body or treat an illness/disease  
Payments to domestic help for nonmedical services  
Retainer or concierge fees

### Miscellaneous Charges

#### Eligible

Sales tax associated with an eligible item  
Transportation expenses primarily for medical care, to include mileage, bus, taxi, parking fees and/or tolls

#### Ineligible

Divorce, even when recommended by a psychiatrist  
Diaper service  
Toiletries or cosmetic items (e.g., toothbrush, soap, lotion, etc.)  
Maternity clothes

## Key Numbers

**Aflac Benefit Services  
Claims Fax:  
1.877.353.9256**

**Customer Service:  
1.877.353.9487**

## Submission Guidelines

Fax your completed Flex One Request for Reimbursement Form and all documentation to: **1-877-FLEX-CLM (1-877-353-9256)**.

***Please allow 48 hours for the receipt of your faxed form before calling to inquire about your reimbursement.***

**Note: Please use discretion when faxing your personal information to Aflac. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to Aflac.**

For account information 24 hours a day, 7 days a week, please use our IVR at 1-877-353-9487.