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**

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

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:
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.

–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. Attached receipts (receipts must have exact dates of services provided).

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
❑					
❑					
❑					
❑					
❑					
❑					

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 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 and 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 Request for Reimbursement Form and all documentation to: **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.