HealthComp
Third Party Administrators

FLEXIBLE BENEFITS PLAN CLAIM FORM

Employee Information

Employer's Name		
Employee's Name (Last, First, MI)		Social Security Number
Employee's Address *If change of address, check box→* ☐		City, State, Zip Code
Home Phone Number	Work Phone Number	Email Address

Claim Information - - Health Care Spending Account

	Date of Service	Name of Provider	Recipient of Services		Claim Amount
			Name	Relationship	
1.					$
2.					$
3.					$
4.					$
5.					$
6.					$
				Grand Total: $	

Claim Information - - Dependent Care Spending Account

	Date of Service(s) From and To		Name of Provider	Recipient of Services		Claim Amount
				Name	Relationship	
1.						$
2.						$
					Grand Total: $	

Dependent Care Provider's Signature: **Date:**

Certification – Read Carefully

To the best of my knowledge, my statements in this claim form are complete and true. I am claiming reimbursement for eligible dependent care expenses and/or unreimbursed medical/dental/vision expenses incurred during the applicable plan year for myself and/or my eligible dependent(s). I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

Employee's Signture: **Date:**

Instructions

√ Complete the appropriate spaces on this form and attach photocopies of applicable Explanation of Benefits or receipts reflecting date of service, the person receiving the service, type of service. Incomplete claims or without proper attachments will be denied.

√ Cancelled checks or balance due statements are not acceptable bills.

√ Any monies remaining in your medical or dependent care account will be forfeited. You will have a run-out period after the Plan year ends to submit expenses incurred during the Plan Year. Please review your Summary Plan Description for your run-out period.

√ Mail Claim to: HEALTHCOMP, P. O. Box 45018, Fresno, CA 93718-5018 or Fax to: Flexible Benefits Dept. (559) 499-2045.

FOR OFFICE USE ONLY

CLAIM #	
PROC DT	
PAYMENT AMT.	
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