FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST

Please mail or fax your claims to: Benefit Coordinators Corporation

100 Ryan Court, Suite 200 Pittsburgh, PA 15205-1324 | Fax: 412-276-7185 / Telephone: 800-685-6100

Visit our homepage at www.benXcel.com for Easy-to-Access forms!

You may also scan or convert your documents to a PDF file and e-mail to: fsa-claims@benxcel.com

EMPLOYER: City of Ontario	GROUP NUMBER: COOCA1	Number of Pages (including receipts): _____
EMPLOYEE NAME: _____		Last Four Digits of SSN: _____

YOUR ADDRESS: ☐ Please check if this is a change in address since you last submitted a claim.

_____
Street

_____ _____ _____
City State Zip

_____ _____
Email Address Fax Number (for return correspondence)

_____ _____
Home Phone Work Phone

PLEASE INCLUDE COPIES OF ALL RECEIPTS AND DOCUMENTATION WITH THIS FORM

HEALTH CARE ACCOUNT EXPENSES

If a health care charge is eligible for full or partial reimbursement from an insurance carrier, the charge must be submitted to all applicable insurance carriers before this plan can make payment. Once the claim has been processed by your insurance carrier, attach your Explanation of Benefits statement (EOB) with an itemized receipt. If the charge does not need to be submitted to the insurance carrier (office visit copays, prescription copays, eligible over-the-counter drugs, etc.) attach your itemized receipt. Do not attach checks or credit card receipts, as the IRS does not recognize these items as valid receipts for this program.

DATE OF SERVICE	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	NET AMOUNT
/ /					$
/ /					$
/ /					$
/ /					$
/ /					$
/ /					$
/ /					$
				TOTAL (required):	$

DEPENDENT CARE ACCOUNT EXPENSES

Attach a copy of the invoice and receipt. Provider's signature is required if there is not a receipt attached.

Provider Name: _____ SS# / TIN#: _____

Address: _____

City: _____ State: _____ Zip: _____

Dependent Name	Dependent Date of Birth:

Date(s) of Dependent Care Coverage: _____

Total Claim: _____

Provider Signature

(In lieu of receipt): _____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. 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. I authorize my Flexible Spending Account to be reduced by the amount requested.

_____ _____

EMPLOYEE SIGNATURE (Required) DATE