MEDICAL REIMBURSEMENT ACCOUNT CLAIM FORM

FLEXIBLE SPENDING ACCOUNT

EMPLOYER NAME: _____

_____
Employee Name

_____
Social Security Number

_____
Street Address **(Apt. No.)**

_____
City/State/Zip

MAIL CLAIMS TO:

NORTH AMERICA ADMINISTRATORS, L.P.
FSA PROCESSING CENTER
P. O. BOX 1984
NASHVILLE, TN 37202

FAX CLAIMS TO:

615-255-6654
ATTN: FLEX CLAIMS ANALYST

PHONE: 615-256-3561 or 800-411-3650

_____ Check if Name Change _____ Check if Address Change

Please enter information for which claim is being made in appropriate sections.

EXPENSES TO BE REIMBURSED:

Name/Relationship	Date of Service	Provider Name	Amount Requested
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

TOTAL AMOUNT REQUESTED: $_____

EMPLOYEE CERTIFICATIONS:

_____ I am covered under an insurance plan (group or individual) or an employer-sponsored employee benefits plan. My explanation of benefits (EOB) forms are enclosed.

_____ I have no insurance coverage for the attached expense(s). I have attached itemized bills and paid receipts.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the extent I am reimbursed from my Spending Account.

SIGNATURE:_____ DATE:_____

DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYER NAME: _____

_____
Employee Name

_____
Social Security Number

_____
Street Address **(Apt. No.)**

_____
City/State/Zip

MAIL CLAIMS TO:

NORTH AMERICA ADMINISTRATORS, L.P.
FSA PROCESSING CENTER
P. O. BOX 1984
NASHVILLE, TN 37202

FAX CLAIMS TO:

615-255-6654
ATTN: FLEX CLAIMS ANALYST

PHONE: 615-256-3561 or 800-411-3650

_____ **Check if Name Change** _____ **Check if Address Change**

Please enter information for which claim is being made in appropriate sections.

EXPENSES TO BE REIMBURSED: **Dependent Name:** _____

Dates of Service From	To	Provider Name, Tax ID No., Address	Amount Requested
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

TOTAL AMOUNT REQUESTED: **$**_____

IMPORTANT: YOU MUST PROVIDE A RECEIPT FROM THE PROVIDER OF SERVICE.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the extent I am reimbursed from my Spending Account.

SIGNATURE:_____**DATE:**_____