

CITY OF NEWPORT NEWS FLEXIBLE BENEFIT PLAN – CLAIM FORM

Employee's name _____ SS# _____

HEALTH CARE EXPENSES _____ I, the participant, hereby file claim for the medical expense(s) noted below and certify that each expense was incurred on the date and for the person and reason noted. The expense(s) listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. **(Benefits Card participants:** I, the participant, further certify that the expense(s) below have not been previously paid for by use of my Benefits Card). **Attached are receipts or bills as evidence of my expenses incurred during the Plan Year.**

** Please note: A doctor's note must be attached if considered a "dual purpose" drug

Date of Treatment	Person treated and Relationship	Type of eligible Expense	Amount of Expense
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL			\$ _____

DEPENDENT CARE EXPENSES _____ I, the participant, hereby file claim for the child or dependent care expense(s) noted below and certify that each expense was incurred on the dates and for the persons noted. I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan. **(Benefits Card participants:** I, the participant, further certify that the expense(s) below have not been previously paid for by use of my Benefits Card). **Attached are receipts or bills as evidence of my expenses incurred during the Plan Year.** Please note that receipts must come from the day care provider and have the dates of service, a description of the expense, the amount charged and the provider's SS# or Tax ID#.

Care Provided By:	Date care provided	Person cared for and Relationship	Amount of Expense
NAME _____	_____	_____	\$ _____
ADDRESS _____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TAX ID # OR SS# _____	_____	_____	\$ _____
TOTAL			\$ _____

PRIVATE INSURANCE EXPENSES _____ I, the participant, hereby file claim for premiums carried individually with a private insurance company and not deducted through my employer or my spouse's employer. I, the participant, certify that each expense was incurred on the dates and for the persons noted. I, the participant, certify that I have not been reimbursed for the expense(s) listed below and that I will not seek reimbursement under any other plan. **Attached are invoices from my insurance companies and canceled checks, payment receipts or bank statements as evidence of payment of premiums for coverage during the Plan Year.**

Period of Coverage	Person(s) Covered	Type of eligible Insurance	Amount of Premium
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL			\$ _____

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

EMPLOYEE'S SIGNATURE _____ DATE _____

Mail This Claim Form To: Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	Fax Claim Form To: Please Include Cover Sheet Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155
--	---

Claims can also be scanned and emailed to FlexDivision@flex-admin.com
 View your account on our website @ www.flex-admin.com or call FBA at (757) 340-4567.

- PLEASE:**
- DO NOT mail your claim form if you fax it.
 - KEEP a copy of all claim forms and receipts for your records
 - NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address