Claim Form

Documentation requirements and instructions on next page.

Employee Last Name, First Name, MI (Please print) | Employer | Social Security Number or Employee I.D.

Street Address | City, State, ZIP Code

Dependent Care Assistance Program

Dependent care expenses must be for a dependent who is incapable of self care or under age 13 when the care was provided.

Name of Dependent	Age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period	ASI Use Only
		From	To*			
		Total Dependent Care Amount Requested →				

***Claims for future services will not be accepted**.

I provided the dependent care as stated above.

Care Provider's **Original** Signature | Date | SSN/Tax ID#

Washington Flex (Health Care Flexible Spending Account)

Date Medical Care or Treatments Received	Provider Name	General Description of Medical Expense	Patient Name	Relation-ship to Employee	Amount that is your responsibility	ASI Use Only
	Total Amount Requested →					

Please attach your documentation in the order listed above.

I certify that all expenses that I am claiming reimbursement or payment for were incurred while I was enrolled in the State of Washington's Flexible Spending Account (FSA) program and/or Dependent Care Assistance Program (DCAP). I have not been reimbursed for these expenses, nor will I seek reimbursement from any other source. The dependent care expenses reported above were provided for my dependent who is under the age of 13 or incapable of self care. I understand that I am fully responsible for the accuracy and completeness of all information relating to the claim(s) above. If an expense listed above does not qualify for reimbursement, I understand I may be liable to pay taxes on any amounts that ASIFlex pays for that expense.

Employee's Signature | Date

Mail or fax (with supporting documentation) to: ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044

Toll-free fax: 1-877-879-9038

Claim Filing Requirements

1. ***Print your name, employer's name, your social security number (SSN) or employee ID, and your street address on the form.***

2. ***List expenses by date and arrange the supporting documents in the same order.***
   Circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
   - Day care claims - Complete the Dependent Care Assistance Program section.
   - Health care claims - Complete the Health Care Flexible Spending Account section. (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense.)
   - Use additional forms if you need to list more items.

3. ***Enclose required documentation.**** A written statement from the dependent care or medical provider (doctor, hospital, pharmacy, etc.) of the service or an insurance company benefits statement showing all of the following:
   - The name of the dependent care or medical service provider.
   - The date(s) of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided**.
   - A description of the service provided (for example, for health care, "dental cleaning", or for day care, "day care").
   - The name(s) of the person(s) receiving the medical or dependent care.
   - The cost of the service, not just the amount you paid.

   ****Dependent care claims only -*** *You may either provide documentation from the day care provider* ***or*** *have the provider complete the Dependent Care Assistance Program section, then sign on the Care Provider's Signature line and date the signature. You do not need to do both.*

   Requests filed without the above documentation **cannot** be processed.

4. ***Sign and date*** the claim form.

5. ***Keep copies*** for your tax records.

6. ***Fax toll-free to 1-877-879-9038 or mail to the address on the first page of this form.***

**You may file claims for orthodontic payments while treatment is in process with a paid receipt from your orthodontist or a copy of the monthly coupon/invoice and your check or credit card receipt. You also must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed, and a paid receipt for an initial down payment or appliance fee.

Over-the-counter (OTC) medicines & drugs: Additional filing requirements under the Health Care FSA:

- You must submit a prescription in order to be reimbursed for any OTC medications.
- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- You must state the existing or imminent medical condition on the receipt, claim form, or on a separate enclosed statement each time these items are claimed.

Medical equipment, vitamins, herbs and nutritional supplements, health club or weight-loss programs, procedures or purchases normally deemed cosmetic, massage therapy, etc.: To claim these items, you must submit a letter of medical necessity from your physician every 12 months stating the nature of your medical condition, the specific item or service needed, and that it is needed for the treatment of this condition. A sample letter is available at www.asiflex.com/pebb.

Claim forms: You may copy this form, go to **www.asiflex.com/pebb** to download it, or call 1-800-659-3035 to request one.

Account detail available 24 hours a day, 7 days a week: Complete history including claims, elections, and available funds at **www.asiflex.com/pebb** (Account Detail). You will need your P.I.N., which you can find on your enrollment confirmation.

Address changes: Addresses are **not** updated from this claim form. Please change your address on file with your employer **and** notify ASIFlex by letter or e-mail to asi@asiflex.com.