MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)
REIMBURSEMENT CLAIM FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

2. UNREIMBURSED MEDICAL BENEFITS

Date Medical Care **Provided***	Name of Medical Provider	General Medical Expense Description. Include medical condition for over-the-counter items.	Patient Name	Relation-ship	Amount that is your responsibility
	Total Medical Amount Requested →				

Please arrange documentation in order listed above**.**

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

3. TERMS AND CONDITIONS

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Health FSA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Employee's Signature Date

SUBMIT YOUR COMPLETED CLAIM FORM TO:

Fax:248-588-4188 or claims@dfbtpa.com
Or Mail to:
DFB TPA FSA Claims
PO BOX 71027
Madison Heights MI 48071