Flexible Spending Account (FSA) Claim Form

THE ADVANTAGE GROUP

Employee Information

Full Name: _____ SSN: _____

Mailing Address: _____ Daytime Phone: _____

City, State, Zip: _____ Employer: _____

Please send photocopies of forms and documents. Keep originals for your records, as claim and supporting documentation become part of this claim record and cannot be returned to you.

Expenses to be Submitted

Attach copies of supporting documentation from your third party provider describing the services and for whom were rendered, date(s) of services (for Dependent Day Care, supporting documentation must indicate "from and to" dates of service as well as the daycare provider's information) and amount paid (such as all invoices, receipts or other supporting documentation). The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, credit card receipts or statements are NOT acceptable documentation of expenses.

expense type (check only one per row)		**expense description**	**person for whom expense was incurred**	**relationship** (spouse, child, tax dependent,or self)	**date of birth** (mm/dd/yy)	**dates of service** (from – to) (mm/dd/yy)		**amount of expense**
health	day care							
☐	☐							$
☐	☐							$
☐	☐							$
☐	☐							$
☐	☐							$
						Total amount to be reimbursed:		$

Day care provider's signature may be substituted for supporting documentation.

Day care provider's signature: _____

Employee Certification

I certify that: I have not been reimbursed and will not seek reimbursement for these same incurred expenses under any other plan and cannot claim these same expenses for an income tax deduction. All of these incurred expenses qualify as eligible expenses for myself and/or my eligible dependents in accordance with the Plan and IRS Regulations. If I have included an over-the-counter medicine, drug or supply, I certify that it is being used "to diagnose, cure, mitigate, treat or prevent disease, or for the purpose of affecting any structure or function of the body." If the over-the-counter item is a supplement, herbal remedy or vitamin, I certify that it is being used for medical care as defined above with the advice of a licensed health care practitioner and not simply to promote general health and have attached the physician's statement. I understand that certain over-the-counter remedies may require additional certification from my health care practitioner.

I certify that all information provided on this form is true and correct to the best of my knowledge.

_____ _____

Signature Date

Claims Submission

Fax to: (877)561-1661

Mail to: 43471 Ridge Park Drive, Suite B, Temecula, Ca 92590

For assistance with claims, contact The Advantage Group Customer Service Center at support@enrollwithtag.com or call toll free (877)506-1660