2016 Health and Limited Health – Flexible Spending Account Reimbursement Request

* Required Field

FLEX_HC

ASSURANT

Submit the completed form along with the appropriate documents to:

Secured Fax number 651.361.4036 **NOTE:** To ensure a timely reimbursement, please complete Employee Information on all copies of the Reimbursement Request and submit via fax. Do not use a cover sheet.

Mail Please mail to address at the bottom of this form if unable to send by fax.

*** * * *Incomplete fields may result in denial of claim* * * ***

EMPLOYEE INFORMATION

Last Name * _____ First Name * _____ MI * _____ SSN (last 4 digits) * _____

** "Dates of Service" must be within 2016 calendar year.** ***Attach documentation in the order listed on this form.****

Box 1

Expense Type* (Submit only one product or expense per box.) Date of Service* _____ MM/DD/YYYY Expense Amount* $ _____

☐ Medical (attach EOB) ☐ Rx (Prescription) ☐ Vision ☐ Dental (attach EOB) ☐ Orthodontist

☐ Eligible Over the Counter Medication with Prescription attached (Medication name required) or Eligible Over the Counter Supplies (Product name required.) _____

Patient's name* _____ Relationship to Employee* _____

Box 2

Expense Type* (Submit only one product or expense per box.) Date of Service* _____ MM/DD/YYYY Expense Amount* $ _____

☐ Medical (attach EOB) ☐ Rx (Prescription) ☐ Vision ☐ Dental (attach EOB) ☐ Orthodontist

☐ Eligible Over the Counter Medication with Prescription attached (Medication name required) or Eligible Over the Counter Supplies (Product name required.) _____

Patient's name* _____ Relationship to Employee* _____

Box 3

Expense Type* (Submit only one product or expense per box.) Date of Service* _____ MM/DD/YYYY Expense Amount* $ _____

☐ Medical (attach EOB) ☐ Rx (Prescription) ☐ Vision ☐ Dental (attach EOB) ☐ Orthodontist

☐ Eligible Over the Counter Medication with Prescription attached (Medication name required) or Eligible Over the Counter Supplies (Product name required.) _____

Patient's name* _____ Relationship to Employee* _____

Box 4

Expense Type* (Submit only one product or expense per box.) Date of Service* _____ MM/DD/YYYY Expense Amount* $ _____

☐ Medical (attach EOB) ☐ Rx (Prescription) ☐ Vision ☐ Dental (attach EOB) ☐ Orthodontist

☐ Eligible Over the Counter Medication with Prescription attached (Medication name required) or Eligible Over the Counter Supplies (Product name required.) _____

Patient's name* _____ Relationship to Employee* _____

TOTAL REIMBURSEMENT REQUESTED (must equal total of above four boxes) $ 0.00

Blue, Green and Orange Plan EOB's can be found at www.anthem.com. **Click "View EOB" and print all pages of Your Claim Recap.** Assurant Dental EOB's can be found at **www.assurantemployeebenefits.com**.

EMPLOYEE CERTIFICATION

With respect to the expenses for which I am requesting reimbursement from the Flexible Spending Account, I certify that:

- The expenses were incurred for services or supplies by me, an individual who qualifies as my spouse or an individual who qualifies as my dependent as defined by the HC FSA portion of the Summary Plan description at http://aha.assurant.com.
- I have not been reimbursed for these expenses in any other way and I have not deducted nor will I deduct these expenses on my individual income tax return.
- If this claim includes a reimbursement request for a prescribed over-the-counter drug other than insulin, I have attached a valid prescription under State law for the first fill, or a copy of a valid prescription for a refill, and I have not exceeded the maximum number of refills authorized by the prescription.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I will notify my Employer in the event that expenses are improperly reimbursed. My employer is authorized to perform an ACH reversal of any funds that are reimbursed in error.

Employee Signature* _____ **Date*** _____

All forms submitted must be signed and dated.

Please allow two weeks for reimbursement.

For additional information, visit the AHA! website at **http://MyAssurantBenefits.com** and click the Flexible Spending link.

Attn: Assurant, Inc. Flexible Spending, 6941 Vista Drive, West Des Moines, IA 50266