NueSynergy
CUSTOMER FOCUSED & TECHNOLOGY DRIVEN

FSA Claim Reimbursement Form

Employer:_____ Social Security Number:_____

Employee Name:_____ Date of Birth:_____

Home Address:_____ City/State/Zip:_____

Work Phone:_____ Email:_____

Change of Address:_____

All plan communication pertaining to your account activity is provided solely via email and the www.NueSynergy.com website. It is important to notify NueSynergy if you change your email address.

1. FSA Medical Expenses

*see below for substantiation requirements

Apply Claim to Plan Year				Service Date(s)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount
	Prior		Current					
	Prior		Current					
	Prior		Current					
	Prior		Current					
						TOTAL FSA MEDICAL CARE EXPENSE:		

2. Dependent Care Expenses

Name of Dependents	Age	Period Covered From | To	Day Care Provider Information: Name	Address	Tax ID	Amount Incurred
					TOTAL DEPENDENT CARE EXPENSE:	

DAY CARE PROVIDER SIGNATURE:

*Health FSA Claims must be substantiated with information from an independent third party (e.g., a receipt or bill) describing the service or product, the date of the service or sale, and the amount of the expense. In addition to facilitating the determination of whether an expense is for medical care, this requirement ensures that the expense has been incurred (i.e., that a health FSA does not make advance reimbursements of future or projected expenses.) Originals, copies/facsimiles, or scanned copies of originals should satisfy this requirement. Credit card receipts or canceled checks do not satisfy the third-party statement requirement.

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 the Employee's Flexible Spending Arrangement with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 on amounts paid from the Plan which relate to such expense.

Participant Signature:_____ Date:_____

Fax or mail completed forms and copies of bills, receipts or invoices to:
Administration Services
4601 College Blvd, Suite 280, Leawood, KS 66211
Fax: 855.890.7238

For office use only:
Amount Approved: *Amount Rejected:* *Reviewed by:* *Date Received:*