Employee Plans
a division of EPIC

Flexible Spending Arrangement Expense Form

OFFICE USE ONLY

Entry # _____
Amount _____

Employer: _____
Employee: _____
SS#: _____
Address: _____

_____

Zip Code: _____
Email Add: _____
Phone: (____) - _____ (____) - _____
Home ***Work***

☐ Check this box if the above is a new address

INSTRUCTIONS: Complete this section below and attached copies of itemized bills with date of service, type of service, and separate charges. Expenses that are covered by your group Plan should be submitted to your insurance carrier first. Expenses that are applied to your deductible or coinsurance payment can be reimbursed by attaching a copy of your "explanation of benefit" form.
BE SURE TO READ THE STATEMENT BELOW AND SIGN YOUR NAME.

Name of person for whom item purchased	*Relationship*	*Date of Service*	*Provider of Service*	*Item purchased*	*Expense*
				TOTALS	

SUBMIT TO: Flexible Spending Arrangement; Employee Plans, 1111 Chestnut Hills Parkway, Fort Wayne, IN 46814
Fax No. 260-625-7530 Email Address: fsa@employeeplansllc.com

I hereby state that this expense is not covered nor will not be reimbursed by any other medical benefit plan, group policy, prepayment plan (HMO), Medicare, Medicaid or any other government plan.

DATE: _____ EMPLOYEE'S SIGNATURE: _____