Managed human resource solutions that maximize the value of people

CERIDIAN freedom

Health FSA Reimbursement Form

page _____ of _____

Fax to: 877-488-6454 **For faster service fax this entire sheet along with the appropriate documentation. Please do not use a cover sheet when faxing.**

Employee Name: Last	First	Middle Initial	Social Security Number
			- -
Home Address ☐ **check if new address** Number/Street	Apt#	City ST Zip	Daytime Phone Number
			( ) -
Email Address ☐ **check if new email address**	Company Name		Client Code
@	General Board of Pensions		IL2172

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature Verification X _____ **Date** _____

Required to process reimbursement

Step 1. Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Health care expenses must be processed by your insurance company first, they will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service is provided, not when you are billed or pay for the service.

For Health Care expenses:

- You must complete the boxes in this section for each expense in order for your claim to be processed properly.
- Use additional page(s) if needed.
- An Explanation of Benefits (EOB) from your insurance company or an itemized bill(receipt) is required to process this claim.
- Your receipts must contain the following:
  - Date of Service
  - Provider of service
  - Type of Service
  - Amount of service
- Drug name must be stated on all receipts.
- Copies of receipts for each expense claimed must be attached to the form.
- Expenses must be totaled on each page.

Date of Service	Provider	Drug Name or Type of Service	Amount of Service
/ /			$.
/ /			$.
/ /			$.
/ /			$.
/ /			$.
/ /			$.
/ /			$.
/ /			$.
	Total Health Care Expenses $		

Step 2. **Fax to: 877-488-6454**. Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed the later of two business days after receipt or prior to your next scheduled reimbursement date. If you prefer, mail to: Ceridian FSA Services, P.O. Box 534134, St. Petersburg, FL 33747. Claims received via mail may require one additional day for processing. Please keep original receipts for your records as required by the IRS.

Visit **www.ceridian-benefits.com** 24 hours a day to obtain account information and additional reimbursement forms. For additional information, please call our customer service center at 877-799-8820, Monday through Friday, between the hours of 8 a.m to 8 p.m. Eastern Time.

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