Mail to:
CBA Blue
PO Box 2365
South Burlington, VT 05407-2365
Fax to: (802) 846-1696

CBA Blue

Flexible Spending Account (Section 125) – Health Care Expense Claim Form

How to file a claim:

1. Complete all sections of the claim form
2. Make sure the claim form does not include items for more than one Plan Year. Please use separate forms for items incurred in different Plan Years.
3. Support documentation is required. Examples of supporting documentation are Explanations of Benefits, Itemized statements from providers, pharmacy receipts, etc. Do not submit cancelled checks or credit card receipts alone – these are **not** adequate.

Employee Information		
Last Name:	First Name:	Mid:
Street Address:	Apt./Unit #	
Birth Date: / / (month / day / year)	Marital Status:	
City:	State:	Zip:
Home Phone: ( )	Alternate Phone: ( )	
Email Address:		
Employer Name:		
Employer Group Number:		
Social Security Number:		

Health Care Expenses (itemize each expense type using a separate line. Use additional forms as necessary)

Patient's Name	Type of Service Please check one box for each expense type: MD = Medical; RX = Prescription; OTC = Over-The-Counter; VS = Vision; DN = Dental HR = Hearing	Date of Service mm/dd/yyyy		Request Amount
	MD ☐ RX ☐ OTC ☐ VS ☐ DN ☐ HR ☐	From:	To:	$
	MD ☐ RX ☐ OTC ☐ VS ☐ DN ☐ HR ☐	From:	To:	$
	MD ☐ RX ☐ OTC ☐ VS ☐ DN ☐ HR ☐	From:	To:	$
	MD ☐ RX ☐ OTC ☐ VS ☐ DN ☐ HR ☐	From:	To:	$
	MD ☐ RX ☐ OTC ☐ VS ☐ DN ☐ HR ☐	From:	To:	$
			Total Expenses	$

I certify that any expenses for which I am requesting reimbursement from my Health Care FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care as permitted by the Health Care FSA, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the FSA program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true.

Employee's Signature _____ **Date** _____

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