Flexible Spending Account (FSA)
Claim Reimbursement Request Form

CHARD SNYDER

COMPANY INFORMATION (PLEASE PRINT)

Company Name	Division (if applicable)

EMPLOYEE INFORMATION (PLEASE PRINT)

First Name	Home Phone ( ) -
Last Name	Work Phone ( ) -
SSN (or Alternate Employee ID)	Email Address (For Account Notifications)
Street Address (Check if New Address ☐)	Apt#
City	State / ZIP

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /
		/ /
		/ /

REIMBURSEMENT REQUEST (PLEASE PRINT)

Please indicate your qualifying expenses below. **DO NOT include expenses reimbursed by any other source.**

HEALTHCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

DATE RANGE OF SERVICES	From / / through / /
DESCRIPTION (Please list a brief description below of services – ie: RX, CoPay, Contact Solution, etc...)	
IMPORTANT: If this is a Limited Healthcare (LFSA) - ONLY submit claims for Dental and/or Vision Expenses.	

TOTAL Healthcare Reimbursement Request

$ _____

(REQUIRED)

DEPENDENT CARE (Daycare) – FLEXIBLE SPENDING ACCOUNT (FSA)

The following information is REQUIRED: Business Name; dates of service and the expense amount; either a receipt/bill OR your Provider's Signature below. NOTE: Cancelled checks are acceptable for daycare expenses only; Credit card statements/receipts are NOT sufficient proof of your claim.

DATE RANGE OF SERVICES	From / / through / /
PROVIDER'S TAX ID (or SSN)	PROVIDER'S BUSINESS or NAME
Dependent Care Provider's Signature:	Date / /

TOTAL Dependent Care Reimbursement Request

$ _____

(REQUIRED)

CLAIM CERTIFICATION

I certify these expenses for which reimbursement is requested on my Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) & are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return.

Signature	Date / /

SEND THIS FORM & A COPY OF RECEIPTS TO CHARD SNYDER (DO NOT SEND ORGINAL RECEIPTS)

Please submit this form with your required documentation to Chard Snyder via one of the three methods listed to the right...

- ☑ **Fax to:** Local (513) 459-9947 / Toll-Free (888) 245-8452 ***(Please DO NOT include a Fax Cover Page)***
- ☑ **Mail to:** 3510 Irwin Simpson Rd, Mason, OH 45040
- ☑ **Email to:** askpenny@chard-snyder.com