FOR FASTER PROCESSING, FAX this Form and Receipts to: 866-395-4543
or Mail Form and Receipts to:
Chappelle Benefits
2740 Ski Lane, Madison, WI 53713
(PLEASE KEEP YOUR ORIGINALS)

BenefitElect
A Division of Chappelle Consulting Group, Inc.

Questions?
Email us at:
customerservice@chappellebenefits.com
or call us at 800-257-0986

FSA & DCA CLAIM REIMBURSEMENT FORM

(Not for FSA Debit Card Receipts)

FSA CLAIM REIMBURSEMENT REQUEST FORM - Receipts received with this form will be processed for reimbursement. *Do not use this form for submitting FSA Debit Card Purchase Receipts* - use the forms in your enrollment/confirmation kit or download those from the web.

Employee Name _____ **Employee ID / SSN:** _____

Daytime Phone Number_____ **Email Address** _____

Employer Name _____

Health Care Reimbursement Claim (HCRA-non-reimbursed medical) - You MUST attach a bill, receipt or Explanation of Benefits (EOB) verifying the date of service or product, type of service or product, name of person receiving service and amount claimed.

	Date of Service	Type	For Whom (name and relationship)	Amount
1.	_____	_____	_____	$_____
2.	_____	_____	_____	$_____

If you have more items to list, please use page 2 of this claim form.

Dependent Care Reimbursement Claim (DCRA) - You MUST attach a bill or receipt from your dependent care provider verifying the dependent's name, name, address and taxpayer ID number (SSN or TIN) of provider, period which services were rendered, description of services and amount. If the Dependent Care Provider signs the appropriate area below, receipts are not required.

	Date of Service	Dependent's Name, Relationship and Date of Birth	Provider's Name and Address	Provider's Tax ID/SSN	Amount
1.	_____	_____	_____	_____	$_____
2.	_____	_____	_____	_____	$_____

PROVIDER CERTIFICATION: I hereby certify that the above Dependent Care charges have been incurred.

Dependent Care Provider Signature _____ Date _____

If you have more items to list, please use page 2 of this claim form.

Outside Premium Reimbursement Account (OPRA) - Attach a bill or receipt indicating the non-company premium healthcare payment

	Date of Service	Type	For Whom (name and relationship)	Amount
1.	_____	_____	_____	$_____
2.	_____	_____	_____	$_____

I hereby certify that all items I requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person nor have these items been paid for by a debit card or stored value card offered with the Flexible Spending Account Plan. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.

*Participant Signature X*_____ *Date* _____

*** IF YOU DON'T HAVE ONLINE ACCESS TO YOUR ACCOUNT, PLEASE PROVIDE YOUR EMAIL ABOVE AND CHECK THIS BOX [ ] - WE WILL EMAIL INSTRUCTIONS. ***

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CLAIM REIMBURSEMENT FORM – Page 2

(Not for FSA Debit Card Receipts)

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Employee Name _____ **Employee ID / SSN:** _____

Daytime Phone Number_____ **Email Address** _____

Employer Name _____

Health Care Reimbursement Claim (HCRA-non-reimbursed medical) - You MUST attach a bill, receipt or Explanation of Benefits (EOB) verifying the date of service or product, type of service or product, name of person receiving service and amount claimed.

	Date of Service	Type	For Whom (name and relationship)	Amount
3.	_____	_____	_____	$_____
4.	_____	_____	_____	$_____
5.	_____	_____	_____	$_____
6.	_____	_____	_____	$_____
7.	_____	_____	_____	$_____
8.	_____	_____	_____	$_____
9.	_____	_____	_____	$_____
10.	_____	_____	_____	$_____

Dependent Care Reimbursement Claim (DCRA) - You MUST attach a bill or receipt from your dependent care provider verifying the dependent's name, name, address and taxpayer ID number (SSN or TIN) of provider, period which services were rendered, description of services and amount. If the Dependent Care Provider signs the appropriate area below, receipts are not required.

	Date of Service	Dependent's Name, Relationship and Date of Birth	Provider's Name and Address	Provider's Tax ID/SSN	Amount
3.	_____	_____	_____	_____	$_____
4.	_____	_____	_____	_____	$_____

PROVIDER CERTIFICATION: I hereby certify that the above Dependent Care charges have been incurred.

Dependent Care Provider Signature _____ Date _____

I hereby certify that all items I requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person nor have these items been paid for by a debit card or stored value card offered with the Flexible Spending Account Plan. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.

*Participant Signature X*_____ *Date* _____