FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT CLAIM FORM

MAIL TO: THE SENECA GROUP/ TPA EXCHANGE: PO BOX 1043, MATTHEWS, NC 28106-1043
OR FAX: 516-977-3333

Company Name:				
Employee Name:			Social Security Number:	
Phone Number			Email Address	
	The claim form MUST be completed. Incomplete forms will be returned by mail. Supporting documentation is required for all expenses (see next page). Please do not write "see attached" in this section. ***Canceled checks, credit card receipts and credit card statements are not acceptable proof of expense***			
Service Dates	Type of Service:	Provider Name	Name and Relationship of person Expense Incurred	Expense Amount:
	Healthcare			
	Healthcare			
	Healthcare			
	Healthcare			
	Healthcare			
	Healthcare			
	Healthcare			
	Healthcare			
Total Dependent Care$		Total Healthcare$		Grand Total:

Dependent Care Provider Signature: _____

Dependent Care Provider Tax ID/SSN: _____

Metered Parking Affidavit: I hereby certify that I have incurred the expenses indicated above in the use of metered parking. If I am required to provide substantiation, then any additional burden of proof will remain my responsibility.

Employee Signature: _____

I request reimbursement for the expenses listed in this claim form under my employer's Flexible Spending Account Plan. I certify that I and or my eligible dependents (as determined under IRS rules) have incurred these expenses. I certify that any medical claim is for medical care excluding cosmetic purposes, is not incurred for general health purposes and does not constitute toiletries or cosmetics. I further certify that I have not received reimbursement for these expenses from any other source and will not seek reimbursement (or a tax deduction) from any other source.

_____ _____

Employee Signature Date

Instructions:

1. All boxes in Section A (employee information) must be completed
2. Complete all blanks of Section B, if expenses for which you are requesting reimbursement exceed the available space, additional form (s) should be used. To avoid delays in processing your claim, do not write, "See attached" in Section B.
3. Sign and date the claim form. (Claim forms received without a signature will be returned)
4. Attach supporting documentation for each claim
5. Do not send cancelled checks, credit card receipts or statements. Only itemized receipts and bills are acceptable proof of expense. (See documentation requirements below)
6. Send the completed claim from and supporting documentation to:

The Seneca Group / TPA Exchange
PO Box 1043
Matthews, NC 28106-1043
Or
Fax: 516-977-3333
Phone: 866-487-4157

Documentation Requirements:

- Healthcare Flexible Spending Account
- Name of employee or dependent receiving care
- Date(s) service was provided (must match claim form)
- Name of service provider
- Type of service provided
- Expense incurred
- Explanation of Benefits (EOB), if applicable, indicating the provider, date(s) of service, amount reimbursed and the amount outstanding
- If you are submitting receipts for prescriptions and RX number must be indicated with your documentation
- If you are submitting for over the counter medications, a copy of the physician's prescription is required

Dependent Care Flexible Spending Account

- Name of dependent receiving care
- Date(s) service was provided (must match claim form)
- Name, address and Tax I.D. Number of service provider. Signature of Provider
- Dates of service
- Expense Incurred

Web site access instructions:

- Go to www.thesenecagroup.com and click "Split Funded (HRA&FSA) Member Login
- User name: Username = EITHER last name2012 OR lastname20121 OR lastname20122
  If just the last name with 2012 does not work, please add the #1 or #2 to the end.
- Password = Social Security Number – the system will prompt you to change this to a personalized password on your first log-in.
- When you log-in with your initial password, you will then have the opportunity to create your own personalized password