CONSOCIATE HEALTH

Flexible Spending Claim Form Instructions

Following, please find helpful instructions for submitting Flexible Spending Claims.

Claim Filing & Documentation Instructions

1. Provide ALL of the information requested on this claim form. Incomplete or unclear information will result in processing delays.
2. Attach an Explanation of Benefits (EOB) or itemized bill from the provider or pharmacy receipt. Documentation should include the provider name, expense description, date of service, amount paid and, if applicable, amount covered by insurance. Credit card receipts, canceled checks, and cash register receipts are not acceptable.
3. Enter dependent reimbursement requests in the box at the bottom of the form.
4. Please be sure to indicate (Y/N) if your claim is a Benny Card transaction.
5. You must submit claims before your grace period ends (usually 60 to 90 days after the plan year ends—check with your HR Department).

MAIL your claim form to:

Consociate
2828 N. Monroe St.
Decatur, IL 62526

- Include the claim form and receipts.
- Remember to keep a copy of the claim form and supporting documents for your records.

OR

FAX your claim form to:

217.233.2281

- Please be sure to number each attachment page (i.e. page 2 of 3, page 3 of 3, etc.)
- If you fax your claim with receipts, please do not follow-up with a hard copy in the mail.
- Remember to keep the original claim form and supporting documents for your records.

OR

EMAIL your claim form to:

fsaclaims@consociate.com

- Include the claim form and supporting documentation.
- Remember to keep the original claim form and supporting documents for your records.

Find your account balance at www.consociatefsa.com

Questions? E-mail flexhelp@consociate.com

CONSOCIATE HEALTH

FSA Claim Form

Check one: ◯ New Claim ◯ Resubmitted Claim
◯ CHECK HERE if you are submitting Debit Card verification receipts at Consociate request.

Employee Name	Daytime Phone Number	Social Security Number	
Street Address	City	State	ZIP
Email Address	◯ CHECK HERE if this is a new address		

Flexible Spending Account Reimbursement

Account Type (Healthcare, Parking, Transit, HRA, HSA, etc.)	Dates of Service From | To	Provider Name	Type of Service or Rx Number	Family Member if applicable	Benny Card Transaction? Y/N	Total
Attach appropriate receipt(s) and submit with this claim form.					Total Medical Care Expense Claim	$

Dependent Care Spending Account Reimbursement

Name of Dependent(s)	Period Covered From | To	Provider Name	Provider Address	Provider Taxpayer ID Number	Total
Provider's Signature (Required if receipt is not provided) _____				Total Medical Care Expense Claim*	$

***NOTE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature: _____ Date: _____

Fax to: **217.233.2281** Email to: **fsaclaims@consociate.com**