

Virginia United Methodist Conference Flexible Spending Account Claim Form

This request is for reimbursement of:

- Health Care Expenses (Complete Sections A, B, and D)
 Dependent Care Expenses (Complete Sections A, B, C, and D)

Mail To:

Aon-Flexible Spending Admin
 7325 Beaufont Springs Drive, Suite 300
 Richmond, VA 23225
 Phone 1-800-481-5224

| | |
|---|---|
| Name _____ | Social Security No. _____ |
| Mailing Address _____ | City _____ State _____ Zip _____ |
| If this is a new address, check here: <input type="checkbox"/> | Daytime Phone _____ |

A. LIST OF EXPENSES (Attach bills, statements, or other evidence of expenses.*)

| Health Care | Date of Service | Payment Made To | Service Provided | Amount |
|--------------------------------------|-----------------|-----------------|------------------|--------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| TOTAL HEALTH CARE EXPENSES | | | | |
| Dependent Care | Date of Service | Payment Made To | Service Provided | Amount |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| TOTAL DEPENDENT CARE EXPENSES | | | | |

*Canceled check is not sufficient evidence.

B. SPOUSE AND DEPENDENT INFORMATION*
 (If expenses were for your spouse or for a dependent)

FOR AON USE ONLY

| | | |
|----------------------------|----------------------------|---------------------------|
| Person's Name _____ | Date of Birth _____ | Relationship _____ |
| Person's Name _____ | Date of Birth _____ | Relationship _____ |

*Your spouse is the person to whom you are married at the end of the year. Your dependent is your child, stepchild, parent, other close relative, or a person who lives in your home, if you provide over half of his/her support.

Amounts

\$ _____
 \$ _____
 \$ _____
 \$ _____

Approved By _____
Date _____

C. DEPENDENT CARE PROVIDER INFORMATION
 (Required unless provider is non-profit organization)

| | |
|-------------------|---|
| Name _____ | Taxpayer ID or Social Security No. _____ |
|-------------------|---|

D. SIGNATURE

I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. In claiming reimbursement for health care expenses, I certify that these expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Bills, statements, or other evidence of these expenses are attached. In claiming reimbursement for dependent care expenses, I certify that my spouse and I will not receive reimbursements in excess of \$5,000 from all employer-sponsored dependent care spending account plans.

Signature _____ Date _____

FORM COMPLETION INSTRUCTIONS:

1. Complete name and address. Reimbursement checks are sent to your home.
2. **Section A.** Complete the necessary information and attach the written documentation including either the provider bill(s) or a copy of the insurance company's explanation of benefits that shows the amounts that went towards the deductible or coinsurance. If you are submitting dependent care expenses, you must provide a copy of the bill as proof that service was rendered. A canceled check is not sufficient based on the IRS regulations.
3. **Section B.** If the claim is for a dependent spouse or child, complete the name, date, and relationship (i.e., husband, wife, son, or daughter).
4. **Section C.** If the claim is for dependent care expenses, you must provide the provider tax ID number or Social Security number if services were provided by an individual.
5. **Section D.** Read, sign, and date.

Claims must be received in our office by Friday of each week. Checks will be mailed the following Wednesday.