



**TOTAL ACCESS FSA
MULTI-PLAN
FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM**

Your Employer Name: _____

Employee Name: _____
(Please print or type)

Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: (_____) _____ - _____
(Area code)

E-mail: _____

Use this form to submit claims for reimbursement from any of the flexible spending accounts you have through Total Access FSA. Be sure to fill in the gray areas and submit any supporting documentation specified under each area.

I. HEALTH CARE EXPENSES

Dates of Expense	Service Provider or Vendor	Amount Paid	Amount Requested
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$	Total:	\$

Supporting Information: For health care expenses you must submit a written **statement from the provider** of services, which describes the services, the dates of services and the charges. If the expense includes deductibles, co-payments or other items not paid by your health insurance plan(s) submit a copy of the **Explanation of Benefits** sent to you by your insurance company.

II. DEPENDENT CARE EXPENSES

Dates of Expense	Caregiver	Amount Paid	Amount Requested
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$	Total:	\$

Supporting Information: For dependent care expenses, attach copies of receipts that indicate name of dependent, name and address of payee, amount paid and period for which payment was

made and, except for certain tax-exempt organizations, the **Taxpayer Identification/Social Security** number of the provider of services.

III. TRANSIT EXPENSES (if applicable):

Expenses for the Month of:	Amount Requested
	\$
	\$
	\$
	\$
Total:	\$

IV. PARKING EXPENSES (if applicable):

Expenses for the Month of:	Amount Requested
	\$
	\$
	\$
	\$
Total:	\$

V. PLEASE SIGN THE FOLLOWING STATEMENT:

I certify that I (or my dependents) have incurred the expenses for which reimbursement is claimed. I declare that these expenses have not been, and will not be, reimbursed under any other insurance plan or other program and will not be claimed as an income tax deduction.

Employee Signature: _____ **Date:** _____

Instructions:

Mail or fax this form and supporting documents to:

Benergy OS
Attn: FSA
353 S. Potomac Street
Waynesboro, PA 17268
Fax: 516-414-5122

If you have any questions, contact Benergy OS by e-mail at FSAclaims@benergyos.com or by phone at 800-768-4909.

Subsequent claims can be submitted with the claim form you receive with your reimbursement check. Thank you for allowing us to be of service.