

Your Employer _____

FlexSystem

REQUEST FOR REIMBURSEMENT

Employer's Client ID# _____

Your Participant # _____

PLEASE DUPLICATE THIS FORM FOR ADDITIONAL REQUESTS

EMPLOYEE NAME & ADDRESS:

How to submit requests:

1. Submit online at www.Freidag.com or
2. Complete this form and
 - a. Fax to 1-608-663-2762 or
 - b. Mail to TASC, PO Box 7308,
Madison, WI 53707-7308

For claim questions call 1-800-422-4661
For additional forms, account balances, election changes, and other information go to www.Freidag.com or call your HR Department.

Use a separate line for each document attached. For each line entered, all fields must be completed. You must attach a copy of an adequate receipt/substantiating document for each item. Retain the originals for your records.

Receipt Attached	Date of Service (not billing or paid date)	Benefit Code	Service Type Code	Request Amount	Service Provider(s)	Office Use Only
<input type="checkbox"/>	___/___/___	___	___	_____.____		<input type="checkbox"/>
<input type="checkbox"/>	___/___/___	___	___	_____.____		<input type="checkbox"/>
<input type="checkbox"/>	___/___/___	___	___	_____.____		<input type="checkbox"/>
<input type="checkbox"/>	___/___/___	___	___	_____.____		<input type="checkbox"/>

BENEFIT CODES

M – MEDICAL EXPENSE – OUT OF POCKET
D – DEPENDENT CARE / DAYCARE

SERVICE TYPE CODES

OT – OVER THE COUNTER DRUG
RX – PRESCRIPTION DRUGS
VI – VISION
DN – DENTAL
MD – OTHER MEDICAL EXPENSES

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Employee Signature (required) _____

Date ___/___/___

REIMBURSEMENT TIPS

Tips to ensure prompt and accurate reimbursements.

- Incomplete Requests for Reimbursement will delay processing.
- Use only your personalized Request for Reimbursement Form. **Please duplicate this Form for future requests.** (*Non-conforming reimbursement forms will be rejected.*) One request form can be used for multiple expenses.
- When completing the Request for Reimbursement Form enter each different expense on a separate line, identifying the date of service, the benefit type, the service type, and the service provider. **Dates of Service always represents the date your services are incurred or rendered.**
- All of the benefit types in which you are enrolled will be listed at the bottom of the Request for Reimbursement Form, along with a corresponding Benefit Code. Place the appropriate code in the box marked Benefit Code. All boxes must be completed on each line for which you are requesting a reimbursement.
- Enter the appropriate codes:

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- Enter the amount requested for each Benefit Code in the Request Amount box for that benefit.
- **You must sign each** Request for Reimbursement Form and/or *VeriFlex* Cover Sheet submitted FlexSystem.
- Although reimbursements may be processed prior to expense substantiation (if offered by your employer), all medical expenses must be substantiated by the Participant and verified by FlexSystem. Fax or mail the receipts with your Request for Reimbursement Form faxed to FlexSystem at 608-663-2762 or mailed to TASC, P.O. Box 7308, Madison, WI 53707-7308.
- If submitting requests on-line, submit your substantiation documents with the *VeriFlex* Cover Sheet, available from the web site after submission of Requests for Reimbursement. Forward the *VeriFlex* Cover Sheet with the substantiation documentation by fax (1-800- 296-3529) or mail (FlexSystem, PO Box 8837, 2302 International Lane, Madison, WI 53704-8837). **Caution:** This toll-free fax number is for **VeriFlex Cover Sheets and substantiating documents only**. All other documents sent to this number **will be destroyed**.
- While supporting documentation may not be required for your non-medical Request for Reimbursement, nevertheless all Participants are expected to maintain supporting records and documents to validate the expense type and amount. FlexSystem may require additional information or documentation prior to processing a claim.
- FlexSystem daily processes checks and Requests for Reimbursement, which when received at TASC by noon CST will be processed that business day, with a corresponding payment issued the following business day.
- Access Participants' account status information on the Internet (at www.accesstasc.com and click on the link), or on FlexSystem's
- Interactive Voice Response System (at 1-800-422-4661, and press 3). Participants will need their Client ID, Participant ID and Pin Number to access this information.

