Flexible Spending Accounts
Section 125
REIMBURSEMENT REQUEST FORM

J.P. FARLEY CORPORATION
WE HAVE A BETTER PLAN.

P.O. Box 458022 • Westlake, Ohio 44145
Toll Free: 800.634.0173 • **Fax:** 440.250.4301
benefits@jpfarley.com • **www.JPFarley.com**

Employer	Branch Location	Group Number
Employee's Last Name	First M.I.	Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
Home Address	Street ☐ Check here if new	Social Security Number (000-00-0000)
City	State Zip	If Name Change, Give Former Name
Home Phone ( ) -	Work Phone ( ) -	Email Address

▼ ATTACH RECEIPTS & DOCUMENTATION ▼

▶ Provide Reimbursement Request Details:

☐ **HEALTH CARE REIMBURSEMENT CLAIM(S)*** $ _____

Documentation includes a copy of the billing, a receipt which indicates the performance and payment of this service, a copy of an explanation of benefits form from your medical carrier or doctor's prescription as applicable to your particular reimbursement request.

- Provider Name
- Address
- Patient Name
- Actual Date(s) of Service
- Description of Service
- Proof of Liability/Service

* *Those who participate in a Health Savings Account (HSA) plan are permitted only to participate, according to IRS regulations, in a Limited Purpose Health Flexible Spending Account arrangement. This means that HSA dollars must be used for the reimbursement of medical claims while Flexible Spending Account (FSA) funds are used for other qualified expenses (i.e. dental or vision expenses).*

☐ **DEPENDENT CARE REIMBURSEMENT CLAIM(S)** $ _____

Supporting documentation must include the following information.

- Provider Name
- Address
- Dependent(s) Name
- Dependent(s) Date of Birth
- Date(s) of Service
- Tax ID (company) / SSN (if individual)

☐ **OTHER QUALIFIED FLEX REIMBURSEMENT CLAIM(S)** $ _____

Include **Transportation/Parking Reimbursement Claims**, *if this benefit is offered by your employer.*
Supporting documentation for **Individual Insurance Premium Claims** must include an itemized statement.

▶ Note: Proper supporting documentation must be attached to validate all submissions for reimbursement. Attach additional documentation as needed for each claim.

▶ Acknowledgement: I validate that the requested reimbursements are accurate and all services have been completed. Further, I validate that I have not been or cannot be compensated for these from any other source.

_____
Signature of Plan Participant Date

▶ Send Claim: Send this completed form and the required documentation to: **J.P. FARLEY**
P.O. Box 458022
Westlake, Ohio 44145