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1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
800.890.0393
Fax: 517.333.6258

OptionALL

Medical Reimbursement Flexible Spending Account (FSA) Withdrawal Request

Part 1 EMPLOYEE INFORMATION (Please Print)

Employee Name (Last, First and Mi):	Employee Date of Birth	Employee Soc. Sec. No.
Employee Address City State Zip Code		Daytime Telephone No.
Employer Name	Department/Location	

Part 2 DESCRIPTION OF EXPENSES AND WITHDRAWAL AMOUNT REQUEST
(Please place each expense on a separate line.)

Patient's Full Name	Relationship	Birthday	Dates of Service From	To	Types of Service	Withdrawal Request Amount
					Total Request for Withdrawal	$

Part 3 EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my FSA, I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud or deceive any benefit plan, files a statement or claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

EMPLOYEE SIGNATURE: _____ DATE: _____

SEE INSTRUCTIONS ON REVERSE SIDE →

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EMPLOYEE INSTRUCTIONS

Please read these instructions before completing the FSA Withdrawal Request on the front of this form.

1. Complete all areas of Part 1 “Employee Information.” Complete Part 2 “Description of Expenses and Withdrawal Amount Request.”
2. Read Part 3 “Employee’s Certification for Reimbursement” statement; then sign and date the form where indicated.
3. For expenses that are payable by any benefit plan, attach a copy of the Explanation of Benefit (EOB) to this form. (Generally, your insurance carrier and any other carrier, e.g., your spouse’s or an individual plan, should pay before you request an FSA reimbursement.) Reimbursement amounts should be submitted as they are incurred but payments will be made only after they total $20 or more.
4. For expenses not covered under any benefit plan or identified on an EOB form, attach a copy of the itemized receipt to this form.
5. Make a copy of this form and all attached receipts for your records (optional).
6. Mail or fax this form and medical care receipts to:

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AN IMPORTANT REMINDER

We have made the withdrawal request administrative process as simple as possible, but we remind you of the following important points:

- You must use this form to request all FSA reimbursements.
- Reimbursement dollars are paid to you. They may not be paid to any other person.
- You must attach any itemized receipts or Explanation of Benefits to each withdrawal request form you submit.
- Cancelled checks and non-itemized receipts are not acceptable for proof of expense.
- Incomplete requests will be returned to you for the additional information. They will not be processed until all information is provided.
- Federal law requires that any unused account balance remaining at the end of the plan year be forfeited.

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