

**FOR BUSINESS EMPLOYEES ONLY
HEALTH FSA EXPENSE REIMBURSEMENT VOUCHER**

Name of Employee (Last, First, MI)		Social Security #
Mailing Address [] Check here if this is a new address; if so, do you have other AF products? Y / N	E-mail address *	
Name of Employer		Daytime Phone #

*You will receive notification by email when payment or direct deposit is sent.

Date of Expense	Name of Person for Whom the Expense Was Incurred	Amount of Medical Expense
		Expense Total: (must be completed)

HEALTH FSA EXPENSE GUIDELINES: ALL DOCUMENTATION ATTACHED MUST HAVE A DETAILED EXPLANATION OF THE DATE, TYPE, AND AMOUNT OF EACH SERVICE RENDERED. REIMBURSEMENTS CANNOT BE MADE UNTIL THE FIRST DEPOSIT OF EACH PLAN YEAR HAS BEEN RECEIVED FROM YOUR EMPLOYER.

Acceptable Documentation to accompany the reimbursement voucher:

- √ Professional bill or receipt that includes:
 - Provider of service
 - Type of service rendered
 - Charges for the service
 - Original date of service

NOTE: the date of service, not the date of payment
must fall within the dates of the plan year for which you are enrolled

- √ Insurance Company Explanation of Benefits
- √ Pharmacy Statement that includes Rx number and name of prescription
- √ **Over-The-Counter Items** – Submit a cash register receipt with name of item, date purchased, amount of item

Unacceptable Documentation includes:

- √ Cancelled checks or credit card receipts
- √ Bill or receipt that only shows a balance forward/previous balance or payment due

I authorize the above expenses to be reimbursed from my Health FSA account. To the best of my knowledge my statements on this form are true and complete. I certify that either I, my spouse, or my dependent (qualifying child or qualifying relative as defined in Code Section 152) has received the services described above on the dates indicated and that the expenses qualify as valid medical care expenses under Code Section 213 (d). I certify that these expenses have not been reimbursed, nor will I seek reimbursement, under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan, a Health Savings Account, or Health Reimbursement Arrangement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I further understand that I may be asked to provide further documentation or further detail relating to an expense.

Signature of Employee

Date Signed

Mailing Address: American Fidelity Assurance Company, AWD/Flex Account Administration, PO Box 268887, Oklahoma City, OK 73126-8887 **PHONE NUMBER:** 1-800-437-1011 **FAX NUMBER:** 1-888-243-2638

American Fidelity will not be responsible for faxes not received. Average processing time is 5 to 7 working days from receipt of a completed voucher. Additional Forms and Account Information are available on our website at: www.afadvantage.com – forms for **Business Employees**.

INCOMPLETE VOUCHERS MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM

KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS