

## HASKINS LABORATORIES FLEXIBLE SPENDING ACCOUNT CLAIM FOR UNINSURED MEDICAL/DENTAL EXPENSES

I hereby certify that the expenses attached hereto qualify for reimbursements as medical or dental expenses under the Flexible Spending Account Plan in accordance with the terms of the Plan and guidelines there under,\* and that I have not received (and will not seek to receive) reimbursement of such expenses under the terms of any insurance policy or other medical/dental benefits coverage.

(Please print)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Total Amount of Claim

*Claims must be received two weeks before the Friday pay date.*

Date Incurred	Name of Service Provider	Expense Description	Expenses Incurred For	Net Amount
Total Expense Claims				

**Enclose the following documentation:+**

- 1) A copy of the bill or receipt from the provider
- 2) Name of Person Treated
- 3) Date of Service and Description of Services Provided
- 4) Insurance explanation of benefits, if applicable
- 5) Receipts must total at least \$25.00

+First-time submission of orthodontia expenses should also include treatment plan contract.

**With regards to claims for uninsured health care expenses, please be sure to mark all claim forms with accompanying documentation as CONFIDENTIAL and submit in a sealed envelope in the Business Office mailbox ( Fresa mailbox ).**

\*Medical and dental expenses must meet the definition of “medical expenses” for purposes of deductibility under Section 213 (e) of the Internal Revenue Code. Expenses that are reimbursed under the Plan may not be claimed as deductions on your federal income tax return; nor may you submit for reimbursement under this Plan any expenses that you have incurred or paid in prior calendar years.