Instructions for completing your Flexible Spending Account Claim Form

Medical Reimbursement Claim Instructions
Before sending in a claim for medical expenses, first submit all of your expenses through your employer’s group health carrier. You will receive an “EOB” (Explanation of Benefits) from the carrier. This explanation will show what portion is ineligible for payment under the insurance program and, therefore, eligible for reimbursement through your medical reimbursement plan. If you are requesting reimbursement for expenses for which you have no insurance coverage (e.g., dental, vision, or hearing), simply complete the claim form and mail or fax with the bill or receipt. The receipt should list dates of service, paid charges, and services provided.

Dependent Care Reimbursement Claim Instructions
You must submit a receipt or statement from the provider of the Dependent Care service. This document must show the dates of service and the name of the dependent for whom care is provided. Expenses may not be submitted until the services are provided. Please note that AmeriFlex requires the following information on each reimbursement request: name of day care provider and tax ID#, dates of service, and type of service (i.e. “day care”). If the receipt is not a printed form with the name of the day care provider, said provider must sign it. Dependent Care expenses are reimbursable when the service is provided, not when the bill is paid. If you prepay for an entire month, the claim will be separated into weekly segments as the service is rendered.

Submission Procedures
For your convenience, claims can be mailed or faxed. When sending your claim, please be sure to fax or enclose copies of appropriate bills, receipts, or EOBs (cancelled checks or credit card statements will not be accepted) pertaining to that claim. Please be sure to sign and date each claim submitted. If the claim form is not complete, your reimbursement request cannot be processed.

Mail Claims to:
AmeriFlex, LLC
Claims Department
303 Fellowship Road
Suite 201
Mount Laurel, NJ 08054

Fax Claims to:
AmeriFlex, LLC
Claims Department
856-631-1020
Flexible Spending Account (FSA) Claim Form

Important: All areas except for “Official Use Only” must be completed in order to process your request.

Employer’s Name: ___________________________ ] Employer’s Phone Number: (____) _______ ________

Employee Name (Last, First, MI): ___________________________ ] Employee Social Security #: _______ _______ ________

<table>
<thead>
<tr>
<th>Date Expense Incurred From–To:</th>
<th>Type of Expense</th>
<th>Name of Patient/Dependent:</th>
<th>Total Amount of Receipts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________</td>
<td>Dependent Care</td>
<td>___________________________</td>
<td>$ ____________</td>
</tr>
<tr>
<td>___________________________</td>
<td>Provider’s tax ID#:</td>
<td>___________________________</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>Medical FSA Expense</td>
<td>___________________________</td>
<td>$ ____________</td>
</tr>
</tbody>
</table>

To the best of my knowledge and belief, my statements in this Claim Form are complete and true. I am claiming 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 on this or any other benefit plan, will not be reimbursed elsewhere, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee’s Signature: ___________________________ ] Date: ___________________________

OFFICIAL USE ONLY

Date Request Received: ___________________________ ] Group ID: ___________________________

Examiner ID#: ___________________________ ] EE ID#: ___________________________

Processing Code: ___________________________ ] Date Processed: ___________________________

Claim forms and accompanying receipts may be faxed or mailed to: