



Flexible Spending Account Claim Form

Do not use for expenses already paid with your FSA card

Name of Employer:

Telephone Number:

Employee's Name:

Total Health Care Reimbursement Requested:

Email Address:

Total Dependent Care Reimbursement Requested:

Social Security Number:

Dependent Care Tax ID:

Mailing Address:

Date of Service	Provider Name	Description	Amount
			\$
			\$
			\$
			\$
			\$
			\$
			\$

The under signed Employee certifies that all expenses hereby submitted are from services incurred during the current plan year

I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Signature: _____

Date: _____

PLEASE ATTACH ALL RECEIPTS AND PROOF OF EXPENSES TO THIS FORM!

Mail to: Section 125 Claims Department
Paragon Benefits, Inc.
P.O. Box 12288 Columbus, GA 31917

Fax to: 706-256-4023
Email to: flex@paragonbenefits.com
For Claims Inquiries Call: 1.866.661.5078