Flexible Spending Account
Claim Form

HOWARD COUNTY PUBLIC SCHOOL SYSTEM

Employee Name (print)

Employee Social Security or ID Number

Home Address (Street, City, State and Zip Code)

☐ ***Check here if new address.***

Email Address

Daytime Phone Number

Unreimbursed Medical Expenses		
Date(s) of Service	**Provider Name**	**Amount**
	Separate sheet may be attached. **Total Amount Requested**	

Unreimbursed Dependent Care Expenses			
Date(s) of Service	**Provider Name**	**Provider SSN or TIN**	**Amount**
	Separate sheet may be attached. **Total Amount Requested**		

Dependent Care Provider Certification (if no receipt is provided)		
I certify that the above listed Dependent Care expenses have been incurred.		
Provider Name (print)	**Provider Signature**	**Date**

Flexible Spending Participant Statement	
I certify that the expenses listed above have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses listed above are eligible for reimbursement under the plan. I certify that any prescription drug expenses submitted are for medical care and not cosmetic purposes. I understand that I am responsible for the accuracy of the information provided to this request. I have not and will not seek to be reimbursed through any other health plan coverage and/or dependent care assistance plan for any of the expenses listed above. I further declare I will not deduct any of the expenses listed above from my federal, state or local tax returns.	
Participant Signature	**Date**

Please mail, email or fax claims and supporting documents to:

Alliance Benefit Group - MidAtlantic, LLC
575 S. Charles Street, Suite 202
Baltimore, MD 21201
Fax: (410) 895-0951
Email with scanned receipts: fsacard@abg-ma.com

Claim Filing Instructions

1. You may submit a Claim Form only if you are a participant in the Flexible Spending Account.

2. You may submit a Claim Form at any time during the Plan Year and for a specified period after your employment terminates as stated in the Summary Plan Description.

3. Reimbursements can only be made for eligible expenses incurred during the coverage period in which your contributions are made.

4. All detailed receipts and other supporting documentation must be submitted with this Claim Form. Detailed receipts must be generated by the provider and include the following information:

Healthcare	**Dependent Care**
Provider's Name	Daycare Provider's Name
Patient's Name	Daycare Provider's Social Security or Tax ID Number
Date the Service was Incurred	Name of the Dependent(s) for whom Service is Provided
Description of Service Provided	Date(s) the Service was Incurred
Amount of the Expense	Amount of the Expense

5. Credit card receipts and/or cancelled checks are not considered adequate documentation and cannot be accepted for reimbursement.

6. Claims will be processed according to your company's pre-determined schedule.

7. The IRS rules stipulate that any money left in your account(s) after all reimbursements for the Plan Year have been processed cannot be carried forward or returned.

8. For a service period which begins in one Plan year and ends in the next Plan Year, you will need to submit two Claim Forms, one for each portion of the period of service that falls in each such Plan Year.

9. Please keep a copy of the Claim Form and your original receipts for your records.

10. For additional information regarding eligible expenses or account detail, please contact us.

Mail: Alliance Benefit Group - MidAtlantic, LLC
575 S. Charles Street, Suite 202
Baltimore, MD 21201

Website: www.fsaplan.info

Email: fsacard@abg-ma.com

Toll-free: 1-877-895-0956

Local: 410-895-0954

Fax: 410-895-0951

Hours: Monday - Friday 7:30 am - 5:30 p.m. E.T.