Section 125 Flexible Benefits Plan
Smartflex Debit Card Expense Substantiation Form

Employee Information

Your Employer's Name

Your Name (Participant)

SSN - -

Daytime Phone

Address

Check if New Address ◯

Email Address (optional)

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Name	*Relationship to Employee*	*Date of Birth*	*Social Security Number*
______________________	______________________	__________	__________________
______________________	______________________	__________	__________________

Please indicate your qualifying expenses below. ***Do not include expenses reimbursed by any other source.*** Attach bills, receipts, Explanation of Benefits summaries (EOBs) or other claim documentation. Documentation must include dates of service, description, provider's name and the expense amount. Cancelled checks are NOT sufficient proof of your claim.

Reimbursement Request

Health Care Spending Account - **Please enter the following claim information:**

Date Range of Service — *Brief description of all attached receipts*

From: __________ ____

To: __________ ____

Total Health Care Debit Card Expense $ __________

Dependent Care Spending Account - **Please enter the following claim information:**

Dates of Service	*Provider's Name*	*Provider Tax ID or Social Sec #*	*Amount*
____________	____________________	____________________	______

Total Dependent Care Debit Card Expense $ __________

Dependent Care Provider's Signature: ______________________ *Date:* __________

Claim Certification

I certify that these expenses for which my Smartflex debit card has been used for the Employee Flexible Spending Account Program have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan or program. I have not and will not itemize and deduct, nor claim credit for these expenses on my individual income tax returns.

Employee Signature ______________________

Date: ____________

(For office use only)

Claim # __________ Denial __________

____
Administrator Initials

Please submit this form along with supporting documentation to:
CSA, 3510 Irwin-Simpson Road, Mason, OH 45040
Phone (800) 982-7715, Fax (513) 459-9947

Employee Flexible Spending Account Program
Smartflex Debit Card Substantiation Instructions

1. Complete all information in **Section 1** (please print or type). **Please include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is processed.**

2. Attach supporting documentation. Substantiation must accompany this request form for all claims received. Be sure to keep copies of receipts, bills, etc. for your records. Originals will not be returned. **All substantiation must include the following items**:
   - Original **date** of service (not the date of payment)
   - **Type** of service performed (refer to list of eligible expenses to identify valid services)
   - Provider's **name** and address (and Tax ID / SSN for Dependent Care expenses)
   - **Amount** charged to you (do not include amounts reimbursed by another source)

3. For a **Healthcare Debit Card Expense**, complete all information in **Section 2** and attach proof of expense as described above. Sales tax is now includable in your total amount.

4. For a **Dependent Care Debit Card Expense**, complete all information in **Section 2** and attach proof of expense as described above unless provider's signature is included on the claim form.

5. Sign and date **Section 3**.

6. **Fax or mail** this form and supporting documentation directly to:

   Chard, Snyder & Associates, Inc.
3510 Irwin Simpson Road
Mason, OH 45040-9744

   Toll-Free: (800) 982-7715
Fax: (513) 459-9947
E-Mail: flex@chard-snyder.com

7. **Important Reminders:**
   - All debit card claims are subject to adjudication. **Transfer between accounts is prohibited.**
   - Any items for which you have been reimbursed **cannot be claimed again** as a reimbursement request to your plan or as deductions or credits on your individual tax return at the end of the tax year.
   - If a **Dependent Care** claim is submitted for an amount that is larger than the amount credited to your account, then payments will be issued according to the amount available. Anything requested above the available amount will "backlog" and will be released as additional credits are made to your account. **IRS Guidelines prohibit the advancement of Dependent Care Account funds**.
   - You may only be reimbursed for eligible expenses incurred **during** the current plan year. *Note: orthodontia expenses are reimbursed as designated by provider.*