

**MONROE COUNTY  
FLEXIBLE SPENDING ACCOUNT  
BENEFIT YEAR CLAIM FORM  
\*Health Care Expenses Only\***

Please read these instructions before completing the claim form:

1. Employee must complete Part I. (If applicable, complete Part II and/or Part III)
2. Instructions for Part II "Health Care Expenses":
  - A. Expenses covered by your spouse's or your health care plan(s) must be submitted to that/those plan(s) prior to submission to your flex medical reimbursement account. Attach a copy of the explanation of benefits statement or itemized bill showing health care plan(s) payment(s) in order to claim your patient responsibility amounts.
  - B. For all other eligible health care expenses, attach an itemized receipt that clearly states the name and address of the provider, date of service, service rendered, name of person receiving the service and the amount charged
3. Read the Employee Statement, sign and date the form.
4. Mail (or fax) the completed form to the address (or fax number) provided on this form.

**Part I: Employee Information** (Please Print)

Employee Name:		Employee Social Security Number: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> </tr> </table>											
Address:		New Address? <input type="checkbox"/> YES <input type="checkbox"/> NO											
Daytime Phone	Evening Phone												

**Part II: Health Care Expenses** (Must fall within first 2 ½ months of current Plan Year)

Covered Person	Date of Service	Provider	Type of Service <small>Please check the appropriate box for each expense(s) MD=medical RX=prescription VS=vision DN=dental OT=other</small>	Amount Claimed	Admin. Use
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> OT <input type="checkbox"/>		
<b>Health Care Expenses Total</b>				<b>\$</b>	

Please note: This claim should only be used if you are choosing to submit health care expenses for services incurred in the first 2 ½ months of the current Plan Year against funds remaining in your Flexible Spending account from the prior year. If there are insufficient funds available in your prior Plan Year account to reimburse you for all the eligible expenses submitted on this form, the remaining expenses will automatically be applied to your current Plan Year account.

**Employee Statement:**

I request payment from my Cafeteria/Flexible Benefits Account for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send completed claim form to: Health Economics Group, Inc. (585) 241-9500, ext. 504  
 1050 University Avenue, Suite A (800) 666-6690, ext. 504  
 Rochester, NY 14607 FAX: (585) 241-9518