FOR OFFICE USE ONLY: Entered:_____/_____/_____ By:________ Claim Number:____

REIMBURSEMENT CLAIM FORM

Monthly statements are processed and mailed to you by the 10th of the each month. Claims are processed within 5 working days of our receipt of the completed and signed claim submission. Dependent Care and Private Premium claims can only be processed to the extent of your account balance(s) at the time of the request. If your claim exceeds your currently available balance, a check will be processed in the amount of your balance, and the unpaid remainder of your claim will be paid with the next monthly deposit processing.

NEW ADDRESS

If reporting a new address, please check the appropriate box below:

- ❑ For this claim only.
- ❑ For this and future claims and reports.

SOCIAL SECURITY NUMBER: X X X X X ☐☐☐☐

FULL LEGAL NAME: ______________________ ______________________ ________
Last Name First Name Initial

COMPANY NAME (Your Employer): ______________________________________

HOME ADDRESS: ______________________________________

CITY: ________________________ STATE: __________ ZIP CODE: ____________________

DAYTIME PHONE NUMBER: (_________)__________________________ Ext:___________ (for Customer Service purposes)

EXPENSES FOR REIMBURSEMENT

Complete the "Listing of Claims Incurred" on the back of this form and carry the totals from boxes [1], [2], and [3] forward to the correct total boxes below.

ALL CLAIMS MUST BE LISTED, ALONG WITH THE DATE(S) OF SERVICE, ON THE BACK OF THIS FORM.

HEALTH CARE EXPENSES	Health plan deductibles, co-insurance, uncovered medical expenses, dental & vision expenses for you and your dependents. **PLEASE NOTE:** If your **HEALTH CARE CLAIM** is larger than your current account balance, choose one of the following payment methods: ☐ Pay monthly as contributions are credited to my account ☐ Pay in full with advance funding from my employer (up to my plan year contrib. commitment)	$ TOTAL HEALTH CARE from [1] on back
DEPENDENT DAY CARE EXPENSES	Expenses incurred for child care or care of a disabled dependent so that you, or you and your spouse if you are married, can work. You must be enrolled in the "Dependent Care Reimbursement Account" to claim eligible child and dependent care expenses.	$ TOTAL DEPENDENT CARE from [2] on back
PRIVATE HEALTH PLAN PREMIUM EXPENSES	Premium reimbursement for your own, your spouse's, or your dependent's private health coverage. You must be enrolled in the "Private Health Premium Payment Account" to claim private health premiums. This account **cannot** be used to pay any employer sponsored payroll reduction premiums. Your payroll deductions for group health insurance premiums are paid on a before-tax basis automatically and do not require a claim form.	$ TOTAL PRIVATE PREMIUM from [3] on back

MANDATORY AUTHORIZING SIGNATURE

I hereby submit the above eligible expenses for reimbursement and understand that it is my responsibility to decide that the items submitted are legitimate expenses which qualify for reimbursement. I have attached necessary supporting documentation in the form of invoices or receipts for every item and I certify that expense(s) submitted by this claim form has not been reimbursed or is not reimbursable under any other health coverage plan.

EMPLOYEE SIGNATURE: ______________________________________ DATE: _____/_____/_____

RETURN THIS FORM TO:

Please STAPLE COPIES of all receipts & invoices to the BACK of this form. Original receipts will not be returned.

LFS BENEFIT SERVICES
2115 West Crescent Ave, Suite 251, Anaheim, CA 92801-3836
QUESTIONS? View your account ONLINE! www.thechoiceaccount.com
or Contact Customer Service: (800) 662-5970 or helpline@lfscc.com

LISTING OF CLAIMS INCURRED

List all eligible claims under the appropriate account below, including date(s) of service for each claim. Total the claims listed under each of the three accounts and carry the three totals forward to the correct boxes.

All dates of service must fall within the plan year against which the claim is being filed. If you are no longer an active participant, the dates of service must be before the date on which your participation terminated (the last day of the month in which you made the last contribution).

HEALTH CARE EXPENSES - Health plan deductibles, co-insurance, uncovered medical expenses, dental & vision expenses

DATE INCURRED	INCURRED FOR (SERVICES PROVIDED)	AMOUNT

[1] TOTAL HEALTH CARE: $

DEPENDENT CARE EXPENSES - Expenses incurred for child care or care of a disabled dependent so that you can work

DATE INCURRED	INCURRED FOR (SERVICES PROVIDED)	AMOUNT

[2] TOTAL DEPENDENT CARE: $

PRIVATE HEALTH PREMIUMS - Premium reimbursement for your own, your spouse's, or your dependent's private health coverage.

DATE INCURRED	INCURRED FOR (SERVICES PROVIDED)	AMOUNT

[3] TOTAL PRIVATE PREMIUMS: $