Limited Flexible Spending Account (LFSA) Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for daims to be processed

1 Personal Information

Employee Name					Company Name			
Street Address, City, State, Zip						Address Change?		
Phone Number			Social Security Number					
2 Limi	ted Healt	th Care	Expenses					
Date of Service		Dantal	N/i= i=		Develop De seivine Couvier	A		
MM	DD	YY	Dental	Vision		Person Receiving Service	Amount	
1								
2								
3								
4								
5								
6								
7								
8								
9								

3 Employee Signature

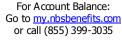
I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature

Date

Total Health Care Expenses

Page 1 of 1 - Welfare-539 (02/2018)



Notice

Claims submitted on this form are for Limited FSA expenses and may include the following: Dental and/or Vision. Please refer to your current SPD to determine which expenses apply.