CONTINUON SERVICES

MEDICAL & DEPENDENT CARE REIMBURSEMENT REQUEST CLAIM FORM

Personal Information: (Please print)			
Employer Name:		**Request Date:**	
Employee Name:		**Email Address:**	
Employee SSN:		**Daytime Phone Number:**	

Health Care Reimbursement Request Expenses (Supporting documentation is required for all claims)

Patient's Name	Relationship to Employee	Age	Date of Service	Type of Service (Medical, Dental, Vision)	Requested Reimbursement
				Total:	

Dependent Care Reimbursement Request Expenses (Supporting documentation is required for all claims)

Dependent's Name	Relationship to Employee	Age	Service Start Date	Service End Date	Requested Reimbursement
				Total:	

Dependent Care Provider Affidavit Information			
Provider's Name:		**Provider's Tax ID or SSN:**	
Dependent Care Provider: Please read the following statement then sign and date. I have provided adult/childcare services to the above listed individuals for the amounts and dates that are listed above:			
Provider's Signature:	**X**	**Date:**	

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT REQUEST

I HEREBY CERTIFY THAT: the above information is correct; I have not received, nor will I seek reimbursement for the expenses listed above from any other plan, including through the use of my Continuon Services MasterCard; the above listed expenses are not eligible for reimbursement under any other plan. ***I ALSO UNDERSTAND THAT:*** reimbursement is not a guarantee that this payment is tax free; healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return; dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return. ***I ALLOW CONTINUON SERVICES OR A REPRESENTATIVE OF CONTINUON SERVICES TO VALIDATE THE SUPPORTING DOCUMENTATION THAT I HAVE PROVIDED WITH DOCTORS, HOSPITALS, MEDICAL CARE PROVIDERS, PHARMACISTS, EMPLOYERS, AND OTHER AGENCIES OR ORGANIZATIONS (INCLUDING OTHER INSURERS) TO PROVE THESE EXPENSES ARE ALLOWED UNDER THIS PLAN AND IRL GUIDELINES.***

Employee Signature:	**X**	**Date:**	

TO EXPEDITE YOUR REIMBURSEMENT, PLEASE COMPLETE ALL INFORMATION AND PROVIDE SUPPORTING DOCUMENTATION.

If you have any questions, please contact us at: 1-877-747-4141 or fsa@csllc.com

Submit to: Continuon Services, LLC
Attn: FSA Administration
P.O. Box 7127
Atlanta, GA 30357-7127

or

Fax to: 1-866-593-7125