SF 4400-SSG (1-2003) Supersedes (11-2002) issue

UCI

MAIL TO:
PayFlex Systems USA, Inc.
Flex Dept.
P.O. Box 3039
Omaha, NE 68103-3039
Phone : (402) 345-0666
(800) 284-4885
www.mypayflex.com

PayFlex Systems USA, Inc.
FSA Claim Form

FAX TO:
PayFlex Systems USA, Inc.
Flex Dept.
(402) 231-4310

(No Cover Page Required.)

Page 1 of _____.

Employee Name: _____ **SSN:** - -

Employer Name: **Sandia National Laboratories**

Note: If you need to make an address change, please contact your employer HR/Benefits office to notify us immediately.

Health Care Claims *(For you or your dependents you claim on your income tax return.)*

If you have medical, dental, or vision insurance, all expenses must be submitted to your insurance company before submitting for reimbursement. When you receive the **Explanation of Benefits (EOB)** statement from your insurance company, submit a copy to us along with this completed claim form. If your insurance is an HMO or PPO for which you have a copay, attach an itemized statement from your provider. ***Do not submit this form if expenses were already paid with your Flex Convenience Card.***

If you do not have insurance coverage for health expenses, submit an itemized statement from the provider showing the **provider's name, address, patient name, date the service was provided, a description of the service, and the amount charged along with this completed claim form.** Balance forward statements, cancelled checks, credit card receipts or received on account statements are **not** acceptable. Prescription drug claims must include the drug name and require the pharmacy receipt (not the cash register receipt) or a printout of prescriptions from your pharmacy. Orthodontia claims require an itemized statement/payment receipt, the orthodontist's contract/payment agreement or monthly payment coupons.

******Information below must be completed – "See Attached" is not acceptable. Additional space on Supplemental form.******

Exact Date of Service MM/DD/YY	Patient Name	Relationship To You	Name of Provider	Description of Service	Amount Requested
				Total	$

Dependent Child or Adult Day Care Claims *(For dependents you claim on your income tax return.)*

Complete this form and attach an itemized statement from your day care provider or have your provider complete the information below. **IRS regulations allow payment for services that have already been provided, not for services in the future.** IRS regulations require the provider to furnish their name, address, and Tax Identification Number (or Social Security Number). If your day care provider completes and signs this form below, no other itemized statement is necessary.

Exact Dates of Service (Past or Current Dates) From	To	Dependent Name	Age	Dependent/Child Care Provider Name	Provider TIN/SSN	Amount Requested
					Total	$

Day Care Provider's Original Signature _____ Day Care Provider's Original Signature _____

Provider Address _____ Provider Address _____

_____ _____

I certify that I have actually incurred these eligible expenses. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature _____ ***Date*** _____

*****Make copies for yourself, since these documents will not be returned. If you fax your claim, keep the original.*****

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SUPPLEMENTAL
FSA Claim Form
PayFlex Systems USA, Inc.
(Health Care Reimbursement Account)

NOTE: Use this Form as a supplement only – *must be attached* to the regular Claim Form.

Employee Name _____ SSN: _____

Employer Name: **Sandia National Laboratories**

Health Care Claims – *Continued*
List each item separately below – do not combine.

Exact Date of Service MM/DD/YY	Patient Name	Relationship To You	Name of Provider	Description of Service	Amount Requested
				Total	$

NOTE:

Eligible Expenses - Health care expenses must qualify as a deductible expense under the Internal Revenue Code as stated in Publication 502 and must also qualify under IRC Section 125. Dependent care expenses must qualify as a deductible expense under the Internal Revenue Code as stated in Publication 503. Check with your tax advisor for questions related to your individual circumstances.