Flex One®/Flexible Spending Account Claim Form

Aflac™

- Please fax this signed and completed form to: 1-877-353-9256.
- For Customer Service, please call: 1-877-353-9487.

1. Participant Information and Signature

By submitting this claim form, I (participant named below) request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and Conditions stated below; I certify and warrant to Aflac that these are eligible Unreimbursed Medical and/or Dependent Care expenses (see back) that my dependents or I have incurred.

Participant Name *(please print)*: _____ **Social Security Number:** _____

Participant Address *(complete only if address has changed)*: _____
Street City State ZIP

Employer Name: _____

How may we contact you during the day? E-Mail: _____ **Phone:** _____

Participant Signature: _____ **Date:** _____

2. Dependent Care

List each receipt separately. Use additional forms if necessary. Use the provider certification space below only if no receipt is attached.

Dependent Name	Age	Provider Name	Date Service Provided	Requested Amount

Provider Certification/Verification: I certify that the Dependent Care expenses listed above were incurred by the participant named above.

Provider Address: Street:_____ City:_____ State:_____ ZIP:_____

Provider Signature:_____ **Date:**_____

3. Unreimbursed Medical

List each receipt separately. Use additional forms if necessary. Use the provider certification space below only if no receipt is attached.

Patient Name	Provider Name	Description of Service	Date Service Provided	Requested Amount

Provider Certification/Verification: I certify that the Unreimbursed Medical expenses listed above were incurred by the participant named above.

Provider Address: Street:_____ City:_____ State:_____ ZIP:_____

Provider Signature:_____ **Date:**_____

4. Terms and Conditions

I (above-named participant) understand and agree that:

- These expenses are not reimbursable from any other health plan, insurance, or other source, and will not be used to claim any federal income tax deduction or credit.
- The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code Section 213(d) and are allowed under Prop. Treas. Reg. 1.125-2.
- The Dependent Care expenses listed above qualify for the federal child care credit, and I will not be eligible to claim the tax credit for any Dependent Care expenses submitted.
- I will include the Taxpayer Identification/Social Security number(s) of any Dependent Care service provider(s) listed above on my annual tax return(s) using Form 2441.
- I am responsible for any inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this information (e.g., fax, e-mail, or any other media).
- I authorize the Plan and its service provider (Aflac), their respective agents, employees, subcontractors, and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan administration purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation.
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above.
- This authorization does not in any way limit any right that Aflac, their respective agents, employees, subcontractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.