OEA Choice Trust

SECTION 125 - FLEXIBLE SPENDING ACCOUNT

Request For Reimbursement Claim Form

Employer Name _____

Employee Name _____ Soc. Sec. #: _____

Address _____

City, State, Zip _____

This request is for reimbursement of: ☐ Healthcare Expenses ☐ Dependent Care Expenses

List of Expenses

IMPORTANT: Instructions for completing a claim form:

1. Complete the entire claim form, including signature and date. Failure to complete the form in its entirety (including the itemization of each expense), and attaching supporting documentation may result in a delay in processing your claim. If more space is required, please attach a separate sheet that includes the same information on this form. You may also enter information with a date range.
2. Attach supporting documentation. Canceled checks, credit card receipts/statements of balance forward or balance due statements are not acceptable.
3. To submit **medical, vision or dental** expenses, attach documentation that includes the date of service, name of provider, the service performed and amount of the charges. An Explanation of Benefits from your insurance company or an itemized billing statement or receipt from your provider is an acceptable form of documentation.
4. To submit **dependent care** expenses, attach documentation that includes the date(s) of service, name and tax ID# or SSN of the provider, who the care was for and the amount of the charge(s).
5. Keep a copy of the completed claim form and supporting documentation for your files.

Date Service Incurred	Payment Made To	Services Provided	Amount
			$
		Total	$

I request reimbursement from my Flexible Spending Account for the above listed expenses paid or to be paid by me. I certify these expenses are not covered or reimbursable from any other source. I understand that I cannot use expenses reimbursed through the healthcare account as tax deductions and I cannot use expenses reimbursed through the dependent care account as a tax credit when filing income tax returns.

Participant's Signature: _____ Date _____

OEA Choice Trust

Please remit claims to OEA Choice Trust - PO Box 23600 - Tigard, OR 97281 or fax at (503) 495-6264
If you have any questions, please call (503) 620-3822 or 1-800-452-0914