

Flex Elect Reimbursement Claim Form

California Department of Human Resources State of California

1. Employee information							
Employee Name (First, MI, I	₋ast)		Social Security Number		Daytime Phone Number		
Mailing Address (Number and Street)			City		State	Zip Code	
			•				
		t Account (day care, babysitting or a dependent who is incapable o		go of 12 at the	time the care	was provided	
Dependent care expenses in	ust be it	n a dependent who is incapable t	or sell care or under the a	ye or 13 at the		was provided.	
Name of Dependent	Age	Name, Address and Taxpayer ID of Care Provider		Date Care Started	Date Care Ended*	Cost for Care Period	ASIFIex use only
			Total Depender	nt Care Amoun	t Requested:		
Care Provider's Signature		Date Signed	S	SSN/Tax ID #	<u> </u>		
* Claims for future convices of	ro not al	igible for reimburgement					

* Claims for future services are not eligible for reimbursement.

3. Medical Reimbur	sement Account								
Date Medical Care Provided (arrange documents in same order)	Name of Medical Provider	General Medical Expense Description. Include medical condition for over-the-counter items.	Person for whom expense incurred	Relationship	Amount	ASIFlex use			
			Total Medical Am	ount Requested:]			
		OF SERVICES or INSURANCE EXPLA ents with a previous balance are not su		•	ent for each e	expense you			
during a period while reimbursement will n the age of 13 or for r veracity of all informa	e I was covered under mot be sought from any only dependent who is intaction relating to this claim be liable for payment	expenses for which reimbursement or party employer's Flexible Spending Plan and other source. Any claimed Dependent Capable of self care. I fully understand im, and that unless an expense for which of all related taxes including federal, standard control of the	and that the expenses of Care Assistance exper that I am fully respons th payment or reimbur	have not been reinses were provide ible for the sufficions sement is claime	imbursed and ed for my depe ency, accurac d is a proper e	endent under y, and expense			
Employee's Signate	ure	Da	te Signed	_					
Submit Form to ASIFlex			ASIFlex						
Along with Support	_		P. O. BOX 6044						
Toll-free fax (877) 87 Online Claims Submi			MBIA MO 65205-6044 et http://ca.asiflex.com						
Online Claims Submi	ission https://my.asiflex	<u>.com</u> Interne	Internet http://ca.asiflex.com						

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Claim Filing Requirements

- 1. Print your name, address, social security number and your daytime phone number (optional).
- 2. List expenses by date & arrange the supporting statements in the same order. Please circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
 - Day care claims complete the Dependent Care Reimbursement Account section
 - Health care claims complete the Medical Reimbursement Account section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).
- 3. **Enclose required documentation*.** A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing all of the following:
 - The name of the dependent care or medical service provider,
 - The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
 - A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),
 - The name of the person or persons receiving the medical or dependent care, and
 - The cost of the service, not just the amount paid.

*Dependent Care claims only. - You may either provide documentation from the day care provider or have the provider complete the Dependent Care Reimbursement section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

Requests filed without the above documentation cannot be processed and will be returned.

- 4. **Sign** the claim form.
- Keep copies for your tax records.
- 6. Mail to the address on the front of this form, submit the claim online, or Fax to (877) 879-9038. This is a toll-free number but employee use of an office fax machine may not be appropriate. Please check with your employer before using an office fax machine.

Online Claims Submission: In order to submit claims online, you must 1) have high-speed internet access, 2) be able to scan your supporting documentation into one or more PDF files that are less than 8MB in size each, and 3) know your P.I.N., which you can find on your enrollment confirmation, or you may obtain by calling ASIFlex's customer service center (800) 659-3035. The website for online claims submission is https://my.asiflex.com. Emailed claims will not be accepted.

Over-the-counter (OTC) medicines & drugs: Additional filing requirements for plans allowing these under the medical FSA:

- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- Starting with purchases January 1, 2011 forward, Federal law requires that you include a prescription in order to be reimbursed for OTC drugs and medicines (e.g. pain relievers, allergy/cold meds, antacids, etc.). This law does not include OTC supplies such as contact lens solution, band-aids, etc.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.

Claims payment and account information available 24 hours a day 7 days a week: Complete history including available funds online at http://ca.asiflex.com (Account Detail). You will need your P.I.N., which you can find on your enrollment confirmation, or you may obtain by calling ASIFlex's customer service center (800) 659-3035.

Claim forms: You may copy this form, obtain forms online at http://ca.asiflex.com, or request them from your personnel office.

Resources

Customer Service: (800) 659-3035 asi@asiflex.com Customer Service Email: https://my.asiflex.com Online claims submission:

Toll-Free Claims Fax: Customer Service Website: http://ca.asiflex.com Claims mailing address:

(877) 879-9038 P.O. Box 6044 Columbia, MO 65205

California Department of Human Resources Privacy Notice on Information Collection

This notice is provided pursuant to the Information Practices Act of 1977.

The California Department of Human Resources (CalHR), Benefits Division, is requesting the information specified on this form CalHR 351 Flex Elect Reimbursement Claim Form pursuant to the requirement set forth in California Code of Regulations Section 599.500(o).

The information collected will be used for verification of your relationship of the dependent child(ren), eligibility verification, payroll deduction, reporting to other state and federal agencies, coordination of benefits with other plans, solution of employee/retiree complaints, grievances, and appeal with the dental and/or vision plan and will be disclosed to The California Public Employees' Retirement System (CalPERS) and/or their contracted administrator, the State Controller's Office, and federal agencies that may require this information.

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR and your employer will not be able to allow your dependent care and medical expenses to be reimbursed.

Department Privacy Policy

The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy located at: http://www.calhr.ca.gov/pages/privacy-policy.aspx.

Access to Your Information

The CalHR Privacy Officer is responsible for maintaining collected records. You have a right to access records containing your personal information we maintain. To request access, contact:

CalHR Privacy Officer 1515 S Street, 500N Sacramento, CA 95811 916-324-0455 CalHRPrivacy@calhr.ca.gov