Flexible Spending Arrangement
Claim Reimbursement Form

Employer: State of Kansas **Kansas Employee ID or Social Security Number (last 4):**

Employee Name: **Date of Birth:**

Home Address: **City/State/Zip:**

Work Phone: **Email:***

☐ **Change of Address**

** All plan communication pertaining to your account activity is provided solely via email and the www.KansasFSA.com website. It is important to notify NueSynergy if you change your email address.*

1. Unreimbursed Medical Expenses **(Copies of cancelled checks, credit card slips or balance due statements are not allowed.)**

Apply Claim to Plan Year	Service Date(s)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount
☐ Prior ☐ Current					
☐ Prior ☐ Current					
☐ Prior ☐ Current					
☐ Prior ☐ Current					
☐ Prior ☐ Current					
☐ Prior ☐ Current					
TOTAL MEDICAL CARE EXPENSE					

**Please note that if a plan year is not selected your claims will be reimbursed out of the first account with an available balance through your grace period, April 30. For example, if a plan year is not selected for a claim date January 1, it will be reimbursed from an available balance of your previous plan year prior to reimbursing out of the current plan year. This is to ensure you do not lose your previous plan year's funds.*

2. Dependent Care Expenses*

Name of Dependent(s)	Age	Period Covered From	To	Day Care Provider Information: Name	Address	Tax ID	Amount Incurred
					TOTAL DEPENDENT CARE EXPENSE		
DAY CARE PROVIDER SIGNATURE:							

** If dependent is over the age of 13, proof of medical diagnosis is not required for claim approval per IRS.*

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Employee's Flexible Spending Arrangement with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

_____ _____

Employee Signature Date

Visit www.KansasFSA.com or call us at 855.750.9440 to check on the status of your claim.

Fax, email or mail completed forms and copies of bills, receipts or invoices to:

Administration Services
10901 Granada Lane, Ste. 100, Leawood, KS 66211
Phone: 913.653.8398, Toll-Free: 855.750.9440, Fax: 855.890.7238
Email: customerservice@NueSynergy.com

Kansas
NueSynergy

For Office Use Only:
Amount Approved: *Amount Rejected:* *Reviewed by:*

9-2012