Benefit Planning Consultants, Inc.

SEND CLAIM FORMS AND DOCUMENTS TO BPC:

Mail:	Fax:	Email Claims	Phone
PO BOX 7500 CHAMPAIGN, IL 61826-7500	217-239-4499 800-295-2990	faxes@bpcinc.com	217-531-9000 877-272-8880

FSA CLAIM FORM

(Please Print) PARTICIPANT NAME:	SSN:	
EMPLOYER: Effingham CUSD #40		
(Required) PARTICIPANT SIGNATURE:	DATE SUBMITTED:	
DAYTIME PHONE:	EMAIL ADDRESS:	
ADDRESS: *(COMPLETE ONLY FOR ADDRESS CHANGE)*	Street City State Zip	

NOTE: Please send copies of forms, receipts & documents. Keep originals for your records, as claim & supporting documentation will not be returned to you. **The IRS has determined that cancelled checks, check carbons, balance forward or previous balance statements, and charge card receipts or statements are NOT acceptable documentation of expenses.** Expenses **MUST** have been incurred during the current Plan Year. All submitted bills/receipts/statement/EOB must be itemized with the date of service, service provided/or item purchased, and the amount charged. **All supporting documentation MUST be attached to this form.** ***Your claim will not be processed until these items are received.***

COMPLETE THIS SECTION FOR CHECK OR DIRECT DEPOSIT CLAIM

Expense Type: FSA: Medical Flexible Spending Account (Flex)

FSA	Expense Description	Dates of Service (From – To)	Provider	Name of person Services provided for	Amount of Purchase
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$

AMOUNT REQUESTED: $

COMPLETE THIS SECTION ONLY FOR BPC BENEFIT CARD DOCUMENTATION

Dates of Service (From – To)	Expense Description	Provider	Name of person Services provided for	Amount of Purchase
				$
				$
				$
				$
				$
				$
				$
				$
				$

I have attached supporting documentation from an independent third party verifying that the medical expense has been incurred and the amount of the expense. By my signature above, I certify that all the expenses are for medical care excluding cosmetic purposes, and are not for general health purposes and are valid expenses under the Plan incurred by myself and/or my spouse and/or my eligible dependents. The expense has not been reimbursed and I will not seek reimbursement under any other plan covering health benefits.

I understand that the expense for which I am reimbursed may not be used as deductions or credits on my or my spouse's income tax return. If I have inadvertently received payment for an ineligible expense, I agree to provide repayment to the Plan.

CHECK YOUR ACCOUNT ONLINE AT: www.bpcinc.com/clients/effinghamcusd.cfm