Aflac™ Flex One® Request for Reimbursement Form

Instructions: Please print or type the information below. **FLEX ONE CLAIM FAX: 1.877.353.9256**

1. Sign and date form.
2. The Total Dependent Care Reimbursement requested box **must be completed.**
3. The Medical Care Total requested box **must be completed.**
4. Receipts attached must be clear and legible.
5. Allow 48 business hours to check status of reimbursement request.
6. **Please maintain copies of all receipts for your records.**

Employee Information ❑ Check here if address change

Participant's Social Security Number	Employer Name		
Last Name	First Name	Middle Initial	Participant's E-Mail Address
Street Address	City	State	ZIP

By submitting this claim form, I request reimbursement from my Flex One account(s) as listed below. I agree to the Terms and Conditions outlined in my employer's Summary Plan Description. I certify and warrant to Aflac that these are eligible medical and/or dependent care expenses that I or my dependents have incurred, are not cosmetic in nature, and cannot be reimbursed from any other source. I will maintain copies of all documentation for my records.

Participant's Signature _____ **Date** _____

Dependent Care Claim Information

For Dependent Care expenses that allow you and your spouse, if applicable, to work. You may file your claim in one of the following ways:

OPTION 1 must include:
1. Date(s) of service (only services received; no future dates).
2. Reimbursement requested (This amt is = to or < than amt charged).
3. Name and age of the dependent receiving care.
4. Provider name, phone number, and dated signature.

–OR–

OPTION 2 must include:
1. Date(s) of service (only services received; no future dates).
2. Reimbursement requested (This amt is = to or < than amt charged).
3. Name and age of the dependent receiving care.
4. Attached receipts (receipts must have exact dates of services provided).

Name/Age of Dependent Receiving Care	Date(s) Services Were Provided	Amount Requested
/	____/____/____ - ____/____/____	
/	____/____/____ - ____/____/____	
/	____/____/____ - ____/____/____	

Total Dependent Care Reimbursement Requested
$ 0.00

Dependent-Care Provider Business Name _____ **Phone Number** _____

Provider's Signature _____ **Date** _____

Medical Care FSA Claim Information

For **Medical Care expenses**, an Explanation of Benefits (EOB) from your insurance company or other receipt(s) must be submitted. ***The EOB and/or attached bills must contain the following items to be processed and approved:***

1. Patient Name **2.** Service Provider **3.** Description of Service **4.** Date(s) Service Was Provided **5.** Amount/Copay

List each receipt separately in the space(s) below. Use additional forms if necessary. A total must be indicated in the Total block below.
Use the Provider Certification space below only if no receipt is attached. Do not indicate "see attached" in the spaces below.

FSA Card Receipt	Patient Name	Service Provider	Description of Service	Date Service Was Provided	Requested Amount
❑					
❑					
❑					
❑					
❑					
❑					

TOTAL $ $0.00

Provider Certification

In lieu of receipts or EOB(s) the provider of the service can certify that the above listed medical care expenses have been incurred and only incurred by either the participant or his/her dependents. Any other expenses must have receipts or a separate completed form. Failure to complete all items will result in an invalid claim request.

Provider Name and Address _____ **City** _____ **State** _____ **ZIP** _____

Provider's Signature _____ **Date** _____

I certify that the Medical Care expenses listed above were incurred by the patient named above.

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