

**Section 125 Flexible Benefits Plan  
Smartflex Debit Card Expense Substantiation Form**



**Employee Information**

Your Employer's Name			Your Name (Participant)		
SSN -   -	Daytime Phone	Address	Check if New Address <input type="radio"/>	Email Address (optional)	

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

<i>Name</i> _____	<i>Relationship to Employee</i> _____	<i>Date of Birth</i> _____	<i>Social Security Number</i> _____
_____	_____	_____	_____

Please indicate your qualifying expenses below. **Do not include expenses reimbursed by any other source.** Attach bills, receipts, Explanation of Benefits summaries (EOBs) or other claim documentation. Documentation must include dates of service, description, provider's name and the expense amount. Cancelled checks are NOT sufficient proof of your claim.

**Reimbursement Request**

**Health Care Spending Account** - Please enter the following claim information:

<i>Date Range of Service</i>	<i>Brief description of all attached receipts</i>
From: _____	_____
To: _____	_____
<b>Total Health Care Debit Card Expense</b>	\$ _____

**Dependent Care Spending Account** - Please enter the following claim information:

<i>Dates of Service</i>	<i>Provider's Name</i>	<i>Provider Tax ID or Social Sec #</i>	<i>Amount</i>
_____	_____	_____	_____
<b>Total Dependent Care Debit Card Expense</b>			\$ _____
Dependent Care Provider's Signature: _____		Date: _____	

**Claim Certification**

I certify that these expenses for which my Smartflex debit card has been used for the Employee Flexible Spending Account Program have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan or program. I have not and will not itemize and deduct, nor claim credit for these expenses on my individual income tax returns.

Employee Signature \_\_\_\_\_

Date: \_\_\_\_\_

*(For office use only)*

Claim # \_\_\_\_\_ Denial \_\_\_\_\_

\_\_\_\_\_  
Administrator Initials

**Please submit this form along with supporting documentation to:  
CSA, 3510 Irwin-Simpson Road, Mason, OH 45040  
Phone (800) 982-7715, Fax (513) 459-9947**

## Employee Flexible Spending Account Program Smartflex Debit Card Substantiation Instructions

1. Complete all information in **Section 1** (please print or type). **Please include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is processed.**
2. Attach supporting documentation. Substantiation must accompany this request form for all claims received. Be sure to keep copies of receipts, bills, etc. for your records. Originals will not be returned. **All substantiation must include the following items:**
  - Original **date** of service (not the date of payment)
  - **Type** of service performed (refer to list of eligible expenses to identify valid services)
  - Provider's **name** and address (and Tax ID / SSN for Dependent Care expenses)
  - **Amount** charged to you (do not include amounts reimbursed by another source)
3. For a **Healthcare Debit Card Expense**, complete all information in **Section 2** and attach proof of expense as described above. Sales tax is now includable in your total amount.
4. For a **Dependent Care Debit Card Expense**, complete all information in **Section 2** and attach proof of expense as described above unless provider's signature is included on the claim form.
5. Sign and date **Section 3**.
6. **Fax or mail** this form and supporting documentation directly to:

Chard, Snyder & Associates, Inc.  
3510 Irwin Simpson Road  
Mason, OH 45040-9744

Toll-Free: (800) 982-7715  
Fax: (513) 459-9947  
E-Mail: flex@chard-snyder.com

7. **Important Reminders:**
  - All debit card claims are subject to adjudication. **Transfer between accounts is prohibited.**
  - Any items for which you have been reimbursed **cannot be claimed again** as a reimbursement request to your plan or as deductions or credits on your individual tax return at the end of the tax year.
  - If a **Dependent Care** claim is submitted for an amount that is larger than the amount credited to your account, then payments will be issued according to the amount available. Anything requested above the available amount will "backlog" and will be released as additional credits are made to your account. **IRS Guidelines prohibit the advancement of Dependent Care Account funds.**
  - You may only be reimbursed for eligible expenses incurred **during** the current plan year. *Note: orthodontia expenses are reimbursed as designated by provider.*