CONTINUON SERVICES

HEALTH REIMBURSEMENT ARRANGEMENT REQUEST CLAIM FORM

Personal Information: (Please print)			
Employer Name:		Request Date:	
Employee Name:		Email Address:	
Last 4 of SSN:	*DO NOT USE YOUR FULL SSN.*	Daytime Phone Number:	

Patient's Name	Relationship to Employee	Age	Date of Service	Type of Service (Medical, Dental, Vision)	Requested Reimbursement
				Total:	

Health Reimbursement Arrangement Request Expenses (Supporting documentation is required for all claims)

Banking Information (For direct deposit reimbursement)			
Bank Name:		Bank City:	
Account Type:	--- Checking --- Savings	Bank State:	
Routing/ABA Number:		Account Number:	

*** ATTACH A VOIDED CHECK ***

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT REQUEST

I HEREBY CERTIFY THAT: the above information is correct; I have not received, nor will I seek reimbursement for the expenses listed above from any other plan, including through the use of my Continuon Services MasterCard; the above listed expenses are not eligible for reimbursement under any other plan. ***I ALSO UNDERSTAND THAT:*** reimbursement is not a guarantee that this payment is tax free; healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return; dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return. ***I ALLOW CONTINUON SERVICES OR A REPRESENTATIVE OF CONTINUON SERVICES TO VALIDATE THE SUPPORTING DOCUMENTATION THAT I HAVE PROVIDED WITH DOCTORS, HOSPITALS, MEDICAL CARE PROVIDERS, PHARMACISTS, EMPLOYERS, AND OTHER AGENCIES OR ORGANIZATIONS (INCLUDING OTHER INSURERS) TO PROVE THESE EXPENSES ARE ALLOWED UNDER THIS PLAN AND IRL GUIDELINES.***

I AUTHORIZE CONTINUON SERVICES, LLC TO DEPOSIT INTO THE ACCOUNT DESIGNATED ON THIS FORM ALL ELIGIBLE REIMBURSEMENTS FROM MY MEDICAL AND/OR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. I AUTHORIZE MY BANK TO ACCEPT AND CREDIT ANY CREDIT ENTRIES AS INSTRUCTED BY CONTINUON SERVICES, LLC. IN THE EVENT THAT CONTINUON SERVICES, LLC DEPOSITS FUNDS ERRONEOUSLY INTO MY ACCOUNT, I AUTHORIZE CONTINUON SERVICES, LLC TO DEBIT MY ACCOUNT FOR AN AMOUNT NOT TO EXCEED THE ORIGINAL AMOUNT OF THE ERRONEOUS CREDIT.

THIS AUTHORIZATION WILL REMAIN IN FULL FORCE AND EFFECTIVE UNTIL CONTINUON SERVICES, LLC AND THE BANK HAVE RECEIVED WRITTEN NOTICE FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD CONTINUON SERVICES, LLC AND THE BANK REASONABLE OPPORTUNITY TO ACT UPON SUCH NOTICE.

Employee Signature:	X	Date:	

TO EXPEDITE YOUR REIMBURSEMENT, PLEASE COMPLETE ALL INFORMATION AND PROVIDE SUPPORTING DOCUMENTATION.

If you have any questions, please contact us at: 1-877-747-4141 or fsa@csllc.com

Submit to: Continuon Services, LLC or Fax to: 1-866-593-7125
Attn: FSA Administration
P.O. Box 7127
Atlanta, GA 30357-7127