



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:

–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. Provider name, phone number, and dated signature.

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

Total Dependent Care Reimbursement Requested
\$ _____

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
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

Provider Certification

TOTAL \$

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.

Helpful Tips for Filing Your Claim

1. Complete, sign, and date the Flex One® Request for Reimbursement Form. Failure to complete all areas will result in claim rejection and a delay in processing and reimbursement. Do not indicate “See Attached” in any field. Descriptions of service should provide as much detail as possible. If a provider certification is used, the provider must sign and date each new claim form.
2. Submit documentation that is clear and legible. Do not highlight information; these areas often turn black when scanned. In addition, double check to make sure all documentation is clearly visible and not overlapped, written through, or cut off if photocopied.
3. Verify that services received are eligible expenses. See below or refer to your *Participant Handbook* for general guidance.
4. The deadline or run-off period for claims submission is determined by your employer. For more information on the run-off period, refer to your Summary Plan Description or contact your employer. To avoid delays, submit your claims at least two weeks prior to the end of your run-off period.
5. Additional reimbursement forms can be obtained at aflac.com or via the IVR at 1-877-353-9487.

Sample Health FSA Expenses

This list is not all-inclusive; for more detailed information, refer to the *Participant Handbook*. Unreimbursed medical expenses are reviewed according to the regulations of Internal Revenue Code Section 125. All claims must be substantiated, and appropriate documentation must be provided. *Some expenses may require additional documentation from your doctor or health care provider.*

Insurance

Eligible

Deductibles, copayments, and coinsurance for medical care plans

Ineligible

All premiums/contributions for insurance
Long-term care plans
Expenses paid totally by your health plan

Treatments/Therapies

Eligible

Prescribed weight loss programs to treat a medical condition (not including foods)
Diagnostic services (e.g., X-ray and MRI treatments)
Smoking cessation programs
Fertility treatments

Ineligible

Illegal treatments
Physical treatments for general well-being or relaxation (e.g., massage therapy)

Fees/Services

Eligible

Physician consultation fees
Routine office visits
Nursing services for care of a specific ailment
Legal sterilization

Ineligible

Cosmetic procedures that improve appearance but do not meaningfully promote the proper function of the body or treat an illness/disease
Payments to domestic help for nonmedical services
Retainer or concierge fees

Medical Equipment

Eligible

Wheelchairs/crutches
Blood sugar monitors
Oxygen equipment
Hearing aids, batteries, or hearing aid repairs

Ineligible

Equipment replacement insurance and/or warranties
Vacuum cleaners for individuals with dust allergies

Dental/Orthodontic Care

Eligible

Routine exams, cleaning, and X-rays
Artificial teeth/dentures
Braces and orthodontic services

Ineligible

Teeth bleaching/whitening
Tooth bonding that is not medically necessary (e.g., cosmetic veneers)

Miscellaneous Charges

Eligible

Sales tax associated with an eligible item
Transportation expenses primarily for medical care, to include mileage, bus, taxi, parking fees and/or tolls

Ineligible

Divorce, even when recommended by a psychiatrist
Diaper service
Toiletries or cosmetic items (e.g., toothbrush, soap, lotion, etc.)
Maternity clothes

Vision Care

Eligible

Prescription eyeglasses
Contact lenses and cleaning solution
Prescription sunglasses

Ineligible

Lens replacement insurance/warranties
Protection plans
Coatings/tints not used to treat a medical condition

Drugs

Eligible

Prescription and over-the-counter drugs to treat a medical condition
Birth control
Insulin

Ineligible

Dietary supplements for general health, to include vitamins and herbs
Drugs for cosmetic purposes

Key Numbers

Flex One Claims Fax:
1.877.353.9256

Customer Service:
1.877.353.9487

Submission Guidelines

Fax your completed Flex One Request for Reimbursement Form and all documentation to: **1-877-FLEX-CLM (1-877-353-9256)**. **Please allow 48 hours for the receipt of your faxed form before calling to inquire about your reimbursement.**

Note: Please use discretion when faxing your personal information to Aflac. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to Aflac.

For account information 24 hours a day, 7 days a week, please use our IVR at 1-877-353-9487.