



HEALTH CARE SPENDING ACCOUNT CLAIM FORM

EMPLOYEE INFORMATION (to be completed by employee)

Form with fields for GROUP NO., EMPLOYER'S NAME, EMPLOYEE'S NAME, MEMBER ID NUMBER, EMPLOYEE'S ADDRESS, IS THIS A NEW MAILING ADDRESS?, (City, State, Zip), EMPLOYEE'S DATE OF BIRTH, DAYTIME PHONE NUMBER, FAX NUMBER, and EMPLOYEE'S E-MAIL ADDRESS.

HEALTH CARE SPENDING ACCOUNT REIMBURSEMENT REQUEST (to be completed by employee)

Amount Requested from my Health Care Account: \$ _____

I certify that either myself and/or my eligible dependents have incurred the expenses for which reimbursement is being claimed from my Health Care Spending Account and that I have not and will not deduct these expenses on my individual income tax return. I further certify this health care expense has not been reimbursed or is not reimbursable under any other employer-sponsored health care plan.

Signature _____ Date _____

Send this form, along with all supporting documentation* to: (Be sure to keep copies for your records.)

BCBSGA Flexible Benefits Department P.O. Box 4463 Chicago, IL 60680-4463

* Supporting documentation includes bills, receipts, and Explanation of Benefit Statements. Canceled checks and cash register receipts are not acceptable forms of documentation, except for over the counter items.

If you have questions regarding your Health Care Spending Account, you may call the Flexible Benefits Department at (800) 844-2946.

