DIVERSIFIED BENEFIT SERVICES, INC.
Excellence in Benefit Management Solutions

Flexible Spending Account (FSA) Claim Form

Claim Filing Options

Online: File a claim online by logging into your account at www.dbsbenefits.com

Fax/Mail: Complete form below and mail or fax to: **Diversified Benefit Services, Inc.**
PO Box 260, Hartland, WI 53029
Fax (262)367-5938

For assistance please call (800) 234-1229.

Participant Information

Participant Name (please print): _____

Email: _____ Last 4 Digits of SS#: ☐☐☐☐

Employer Name: _____

Address Change (if applicable): _____

Participant Signature: _____ Date: _____

Health Care FSA (HCFSA) / Limited Purpose FSA (LPFSA)

Claim Amount: _____

Date(s) of Service (list range if multiple dates): _____ to _____

Attach Documentation Showing:

1) Date of Service 2) Provider 3) Your Out-of-Pocket Expense 4) Type of Medical Expense (medical, dental, vision)

Dependent Care FSA (DCFSA)

Claim Amount: _____

Name of Dependent Care Provider: _____

Service Start Date: _____ Service End Date: _____

Provider Federal Tax ID#: _____ ***or*** Provider SS#: _____

Signature of Provider: _____ **(required if no receipt attached)**

Premium Reimbursement Account (PRA)

Claim Amount: _____ Premium Coverage Dates (within plan year): _____ to _____

Attach Documentation Showing: Independent insurance premium billing.

Claim Authorization - By submitting this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as a tax credit. I certify that I will not be reimbursed for the expenses listed above from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred (having dates of service) during the timeframe required by the benefit plan and are for my own expenses, expenses of my spouse and expenses of my dependent children as defined by my employer's Plan. I will provide documentation necessary to support the amounts being requested for reimbursement. In addition, by submitting this document I acknowledge and agree DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient.