Clear Form

FSA Reimbursement Request Form

This form allows you to request reimbursement for eligible health items, services and if applicable dependent care (daycare) expenses incurred by yourself, your spouse and any federal tax dependents.

INSTRUCTIONS: INCLUDE RECEIPTS AND DOCUMENTATION WITH THIS REQUEST FORM

1. **Complete** all applicable sections of this form. **Remember to sign and date the bottom of this form.**
2. **Attach** all itemized bills, explanations of benefits, statements of service or receipts for your expenses incurred. All supporting documents become a part of this claim and **will not** be returned to you.
3. **Submit** this completed form and supporting documentation to Igoe Administrative Services for review via:
   - Secure Upload through your personal account at www.goigoe.com
   - Email to flex@goigoe.com
   - Fax to 800-456-9083 Please make sure to properly dial the fax number listed on this form. Igoe accepts no responsibility for transmissions that are routed to the wrong location based on dialer error.
   - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
4. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Click For Additional Tips

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Medical Care Expenses Incurred (for participant and all federal tax dependents)

Clear Section B

Service Date (mm/dd/yy)	Name of Doctor / Provider of Services	Description of Expense	Person Incurring Expense Name, Age, Relationship	Net Amount
				$
				$
				$
				$
				$
				$
				$
				$
			Total Medical Care	$ 0.00

Section C: Dependent Care/Day Care Expenses Incurred

Clear Section C

Dates Covered (mm/dd/yy) - (mm/dd/yy)	Dependent Information Name, Age, Relationship	Description of Expense	Name of Provider	Provider's Tax ID or SSN	Net Amount
-					$
-					$
-					$
-					$
-					$
-					$
				Total Dependent Care	$ 0.00

Section D: Authorization *REQUIRED (PLEASE SIGN AND DATE)

As a participant in the Plan, I certify that all above expenses were incurred during the Plan Year while I was covered under the Flexible Benefit Plan and that the expenses have not been or are not being reimbursed under any other benefit plan or charged to my employer's Flexible Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to this request. I further acknowledge that each expense for which payment or reimbursement is requested must be a proper expense under the Plan. If not, I understand that I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSMENT IS MADE. Having agreed to all of the proceeding statements, I authorize the Flexible Benefit Plan Account/s in my name to be reduced by the amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

Ready To Sign? Click To Print

Participant's Signature: _____ **Date:** _____

rev. 140509a

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