MAIL TO:

ATTN: FLEXIBLE SPENDING UNIT
P.O. BOX 981178
EL PASO, TX 799981178
PHONE: 800-842-2026

UNITED STATES
POSTAL SERVICE

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Please Read These Instructions Before Completing The FSA Withdrawal Request

1. Employee must complete **Part 1**. (If applicable, complete Part 2 "Health Care Expenses" and/or Part 3 "Dependent Care Expenses.")
2. Instructions for **Part 2**:
   A. If expenses were covered by any benefit plan, attach a **copy** of the Explanation of Benefits (EOB) along with your FSA withdrawal form. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request an FSA reimbursement.
   B. If expenses are not covered by any benefit plan, attach a **copy** of an itemized receipt that includes the dates of service, service rendered, and total charge.
3. Instructions for **Part 3**: Attach a **copy** of a receipt that includes the dates of service, day care provider's name, and amount paid to day care provider or attach a **copy** of a cancelled check from the day care provider.
4. Read the Certification For Reimbursement, **sign and date the form**. Make a **copy** for your records.
5. Mail the form to the address provided on this form. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.

PART 1 EMPLOYEE INFORMATION (Please Print)

EMPLOYEE NAME (Last and First)	PARTICIPANT ID	DATE OF BIRTH / /	DAYTIME TELEPHONE NO. ( )
EMPLOYEE ADDRESS		FSA GROUP NUMBER **141245**	EMPLOYER NAME **USPS**

PART 2 HEALTH CARE EXPENSES (Please Print) Please place each expense on a separate line

PATIENT'S NAME	DATE(S) OF SERVICE MM/DD/YYYY From:	To:	TYPE OF SERVICES Please check the appropriate box below for each expense(s) MD=medical RX=prescription VS=vision DN=dental HR=hearing	REQUEST AMOUNT
	From:	To:	MD ☐ RX ☐ VS ☐ DN ☐ HR ☐	
	From:	To:	MD ☐ RX ☐ VS ☐ DN ☐ HR ☐	
	From:	To:	MD ☐ RX ☐ VS ☐ DN ☐ HR ☐	
	From:	To:	MD ☐ RX ☐ VS ☐ DN ☐ HR ☐	
	From:	To:	MD ☐ RX ☐ VS ☐ DN ☐ HR ☐	
			HEALTH CARE EXPENSES SUBTOTAL	$

PART 3 DEPENDENT CARE EXPENSES (Please Print) Please place each expense on a separate line

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICE MM/DD/YYYY From:	To:	TYPE OF SERVICE(S)	REQUEST AMOUNT
		From:	To:		
		From:	To:		
				DEPENDENT CARE EXPENSES SUBTOTAL	$

TOTAL REQUEST FOR WITHDRAWAL	$

CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or/we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) income tax return.

PRIVACY ACT: Completing this form, which is used to process withdrawals from your account, is voluntary; however, without the information, we will be unable to process your request. Your copy of PS8200 "FSA ENROLLMENT FORM" includes a Privacy Act statement that lists the routine uses for which this information may be disclosed. If you are unable to locate your copy, you may obtain one from your personnel office. Authority: 30 U.S.C. 401, 1001, 1003, 1005: 5 U.S.C. 8339

EMPLOYEE SIGNATURE: **DATE:**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.