



TaxSaver Plan Debit Claim Fax Cover Sheet
214-528-8122 fax
800-328-4337 phone

Participant Name: _____
Social Security Number: _____
Employer: _____
Date: _____
Pages (including this cover): _____
Amount of Debit Transaction: _____

All questions should be sent to csr@taxsaverplan.com or 800-328-4337 or you may review your account at www.taxsaverplan.com. Copies of credit card receipts or canceled checks, balance due or payment of account are not acceptable forms of receipt and will be returned for more information. Claim substantiation must include the date of service rendered and the type of service rendered. Over the counter items should be listed by name of purchase.

Once you have sent your fax, you may go online to receive confirmation that your fax has been received by clicking on “Find-A-Fax”.

By submitting this fax cover sheet, I further testify that I have attached records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my spending account that they may not be claimed on any federal income tax deduction or credit at year end. I further certify that I will not submit these expenses for payment by a third party, such as my major medical plan, or any other health plan, such as an individual policy or my spouse’s or dependents health plan.

Because this expense was paid for with my Flex Debit Card, I understand that the card is not to be used for personal items, other than eligible expenses under the Plan. Should I use the card for ineligible expenses, I am required to reimburse the Plan for the ineligible expenses paid for by the card. I attest that any over the counter expenses have been incurred for the primary purpose of the alleviation or prevention of a physical or mental defect or illness and is not for cosmetic purposes and will be used by myself, spouse and/or dependents. Lastly, I attest that these expenses are solely for myself, spouse or tax dependent as defined under Code Section 152.