TaxSaver Plan Standard Claim Form Instruction Sheet

Please complete the steps below to submit the Standard Claim Form. Incomplete submissions may result in delays in processing your request. TaxSaver Plan will contact you if more information is required to process your claim.

Print the full Employer Name, Participant Name, and Social Security Number (at least the last 4 digits) in the spaces provided.

- Check one request type option only.
- **For Flex Debit Card transactions only:** you may use the Debit Card Substantiation Worksheet to simplify your submission process. You'll find it in the "Forms" section of our website.
- Fill in the total amount you are claiming for each Plan that applies to your request. You may submit expenses for more than one type of plan using the Standard Claim Form.
- Sign and date the bottom of the form.
- For each expense you claim, you must attach matching documentation from the service provider. See below for specific information on what documentation is necessary for each type of plan.

Submit your claims to:

Taxsaver Plan
P.O. Box 609002
Dallas, TX 75360
214-528-8122 FAX
claims@taxsaverplan.com EMAIL
www.taxsaverplan.com SECURE WEBSITE

Health Flexible Spending Arrangement (Health FSA): Acceptable documentation for expenses include:

1. Health plan receipts (Explanation of Benefits) sent from your health plan provider that substantiate deductibles, co-pays, coinsurance or other expenses not covered by a health plan, or
2. itemized receipts from health care providers that substantiate the date of service, type of service, cost of service and the name and phone number of the provider or
3. itemized receipts for eligible over-the-counter expenses with the name of the drug or item and the date of the purchase printed on the receipt from an independent third party.

Please note: balance forward statements, canceled checks and credit card receipts are not acceptable.

True Up Health Flexible Spending Arrangement (TU FSA): Acceptable documentation for expenses include:

1. Health Plan receipts (Explanation of Benefits) sent from your insurance plan provider that substantiate deductibles, copays, coinsurance or other expenses applicable toward or covered by the employer-sponsored plan that covers you, your spouse and/or any eligible dependents.
2. Itemized receipts (as indicated above in the Health Flexible Spending Arrangement section) are acceptable for expenses for yourself or any eligible dependents that are not applicable to or covered by your employer-sponsored insurance plan. You must indicate which portion of your total claim is applicable toward your insurance plan and which portion is not.

Health Reimbursement Arrangement (HRA):
HRA plans vary in terms of expenses eligible for reimbursement. Please refer to your Plan SPD for specific information about eligible expenses under your plan and what documentation is required to substantiate those expenses.

Dependent Care Assistance Program (DCAP):
You must submit itemized receipts that substantiate the date of care, amounts paid for care and the name of the provider OR have your provider sign and date the form certifying that the services have been rendered. Please include the dates of service on the claim form.

TaxSaver Plan Standard Claim Form

Submit Claims To:
Taxsaver Plan
P.O. Box 609002
Dallas, TX 75360
214-528-8122 FAX
claims@taxsaverplan.com

Full Employer Name **Full Participant Name** **Social Security Number**

Participant Phone Number **Participant Email Address**

Your employer may have a customized claim form specific to your plan, which can be found by securely logging in to your personal account page at www.taxsaverplan.com. Using the customized form under your login ensures accurate and timely processing of your claim. On the website, you can also submit claims directly with no printing required, contact TaxSaver Plan, and view your up-to-date individual account details. Please contact our Customer Service Department with any questions at 800-328-4337 or email csr@taxsaverplan.com.

Request Type - *Please check **one** option only:*
_____ This is back-up documentation for a Flex Debit Card transaction
_____ This is to offset a Flex Debit Card transaction with out-of-pocket expenses
_____ This is a request for reimbursement for out-of-pocket expenses
_____ This is a combination request for reimbursement & back-up documentation for a Flex Debit Card transaction

Plan Type - *Please fill in the total amount you are claiming for each Plan that applies to your request:*

1. Health Flexible Spending Arrangement (Health FSA) $_____

2. True Up Health Flexible Spending Arrangement (TU FSA) $ _____

   - *Please list the out of pocket amount of your claim applicable toward your insurance plan: $_____*
   - *Please list the out of pocket amount of your claim not applicable toward your insurance plan: $_____*

3. Health Reimbursement Arrangement (HRA) $_____

4. Dependent Care Assistance Program (DCAP) $_____ Dates of Service: __ / __ / ____ to __ / __ / ____

I _____ (print provider name) certify that I have provided dependent care services on the date(s) listed above.

Day Care Provider Signature *Date of Signature*

Each Plan requires specific documentation to be submitted with this form for reimbursement or substantiation. Please see the Standard Claim Form Instruction Sheet for the specific documentation required for each Plan.

Participant Certification - *This section must be signed and dated for reimbursement requests:*

I testify that I have attached the records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my spending account, 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 another employer reimbursement plan or spouse's or dependent's reimbursement plan. If 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. I attest that all expenses are for myself, eligible spouse and/or dependent(s).

Date **Signature**