



DESERET MUTUAL USE ONLY

FLEXIBLE SPENDING ACCOUNT CLAIM FORM FOR MEDICAL & DENTAL EXPENSES

TO AVOID DELAY, READ AND COMPLETE THE ENTIRE FORM

EMPLOYEE	DESERET MUTUAL IDENTIFICATION NUMBER	EMPLOYER NAME	
STREET		CITY	STATE ZIP CODE
HOME TELEPHONE ()		WORK TELEPHONE ()	

SIGNATURE

I certify that these expenses are not reimbursable from any other benefit program and will not be claimed as income tax deductions. I am requesting reimbursement only for qualifying expenses incurred during the plan year for eligible participants. I authorize my Flexible Spending Account(s) to be reduced by the amount requested.

Policy Holder's Signature: _____ Date: _____

Expenses incurred between January 1 and March 15 are eligible for reimbursement from either the current or the previous Flexible Spending plan year. If you are seeking reimbursement for expenses incurred within that time period, please mark one of the boxes below to indicate which plan year you would like these funds to be reimbursed from first:

Previous Year	Current Year
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If you do not indicate the plan year from which you are seeking reimbursement, eligible expenses will be paid using the previous year's balance (if one exists) until it has been exhausted or until all eligible expenses have been paid.

TOTAL EXPENSES BEING CLAIMED

MEDICAL / DENTAL / PRESCRIPTION SERVICE(S): INCLUDE PATIENT'S NAME AND SERVICE DATE	TOTAL AMOUNT
	\$

If you are seeking reimbursement for multiple expenses, please list the total amount being claimed in the box above. You can use the worksheet on the back of this form to itemize the expenses you are claiming.

DOCUMENTATION REQUIRED FOR MEDICAL & DENTAL EXPENSES:

- Attach a copy of the Explanation of Benefits or the denial letter from Deseret Mutual or another third-party payer. If these items are not attached, your claim will not be reimbursed until you submit proper documentation.
- If the expenses are for services excluded from your medical/dental coverage (glasses, contact lenses, etc.), attach a copy of the itemized bills. You can obtain an itemized bill from the service provider. It should include the name of the patient, the date services were rendered, the total amount being claimed, and a detailed description of the product or service.
- **Balance due statements are not accepted!**
- Cancelled checks are only accepted for orthodontics. You may also submit receipts from the orthodontist showing the payment date, the amount paid, and the name of the patient.

CAREFULLY READ THE BACK OF THIS FORM. YOUR CLAIM WILL NOT BE PAID IF YOU DO NOT SUBMIT THE CORRECT INFORMATION OR YOU DO NOT SIGN THE FORM ABOVE. RECEIPTS SHOULD BE SUBMITTED ON A SEPARATE PIECE OF PAPER.

