Return Claim Form and Documentation To:
Toni Ann Amature, Benefits Administrator
Independent Pension Services, Inc.
114 Old Country Rd., Ste. 520, Mineola, NY 11501
Phone: 516-747-5210 Fax: 516-385-2124
Secure Email: https://independentpension.securefilex.com

HEALTH FSA CLAIM FORM

I. Participant Identification (Please print or type)

Company/Location: ____________________

Participant Name: ____________________

Mailing Address: ____________________

____

Social Security Number: ______-______-______ Email: ____________________

II. Attach Explanation of Benefits (Please use a separate sheet if more space is needed)

Date of Service	Physician or other Provider	Amount	Patient's Name	Self	Spouse	Dependent
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐
		$		☐	☐	☐

III. Total Amount Requested $ ________

IV. Statement by Participant

To the best of my knowledge and believe my statements in this Form are complete and true. I certify that: either I or a family member has received the services described above on the dates indicated, the expenses are out-of-pocket expenses that qualify as valid Medical Care Expenses under the Plan, and that these expenses have not been reimbursed or are not reimbursable under the major medical plan or any other health plan such as my Spouse's Plan.

____________________ ____________________

Participant's Signature Date

For administrative use only

Reviewed by: IPS/TONI ANN Date: __________ Plan Year: __________ Benefit: FSA

Approved: $_______.___ Denied: $_______.___

Reason For Denial: ____________________ Action To Be Taken: ____________________