

**Submit your claim online!**<https://my.asiflex.com>

You will need your PIN to submit your claim online. If you don't have your PIN, call ASIFlex at (800) 659-3035.

**Claim Form**

Please print clearly

**Go Paperless!**

Sign up to receive communication from ASIFlex via email rather than US Mail. Complete the email notification form at [www.asiflex.com](http://www.asiflex.com).

<b>Name (Last, First, MI)</b>	<b>Social Security Number or EID or PIN</b>	<b>Employer</b>	
<b>Mailing Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>

**Dependent Care Flexible Spending Account**

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	Age	Dates Care Provided		Name and Address of Care Provider	Cost for Care Period
		From	To*		
<b>Total <u>Dependent Care</u> Amount Requested</b>					

I provided the dependent care as stated above. \_\_\_\_\_  
 \_\_\_\_\_  
 Dependent Care Provider's **original** signature      Date

\*Claims for future services are **not** eligible for reimbursement and will not be processed.

**Health Care Flexible Spending Account**

Date Medical Care <b>Provided</b> *	Name of Medical Provider	General Medical Expense	Name of person receiving service/care	Relationship	Dollar amount that is your responsibility
<b>Total <u>Health Care</u> Amount Requested</b>					

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care Assistance expenses were provided for my dependent under the age of 13 or for my dependent who is incapable of self care. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Claims Submission**

Toll-Free Fax: (877) 879-9038

Online Claims Submission: <https://my.asiflex.com>

US Mail: P.O. Box 6044, Columbia, MO 65205

**Resources****Customer Service**Website: [www.asiflex.com](http://www.asiflex.com)

Toll-Free Phone: (800) 659-3035

Email: [asi@asiflex.com](mailto:asi@asiflex.com)