Claim Reimbursement Form

Transit, Parking, Commuter, Cell Phone, Medical, Dental and Vision Expenses

Complete the form below and provide proof of expense for the claims listed below. Claims submitted without proof of expense are not reimbursable. A copy of a bill or other written statement from the provider of service is acceptable. Please be sure to attach a complete itemized bill. Your reimbursement check will be mailed to the address listed below unless you are enrolled in direct deposit reimbursements.

Personal Information

(Please print clearly)

Employer: _____

Employee Full Name: _____

Social Security Number: _____ **Cell Pone#:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Claim Information

Type of Expense: _____ **Amount:** _____

Type of Expense: _____ **Amount:** _____

Type of Expense: _____ **Amount:** _____

Type of Expense: _____ **Amount:** _____

Type of Expense: _____ **Amount:** _____

Type of Expense: _____ **Amount:** _____

Total: _____

Participant Signature: _____ **Date:** _____

- **By signing this form, I agree to have my account reduced by the amount requested.**
- **This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.**
- **These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.**
- **If additional information is required you will receive a denial letter letting you know what additional information is needed.**
- **Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact you employer to see if advance payments for orthodontia expenses are allowed.**
- **Mail/email/fax all documents to the contact information.**

Mail the completed form to:

FBA National
100 Quentin Roosevelt Boulevard
Suite 403, Garden City, NY 11530
Phone: (855) 374-6431
Fax: (833) 930-1024
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