Superior State Employer Solutions Claim Form FSA HRA HSA

Employer	
Employee Name	Social Security Number
Employee's Home Address (Number/Street City, State, Zip)	

Expense Detail

Name ________	**Name** ________	**Name** ________
Relationship to Employee (check one)	**Relationship to Employee (check one)**	**Relationship to Employee (check one)**
☐ Self	☐ Self	☐ Self
☐ Spouse	☐ Spouse	☐ Spouse
☐ Dependent	☐ Dependent	☐ Dependent
Type of Service (check one)	**Type of Service (check one)**	**Type of Service (check one)**
☐ Health Care	☐ Health Care	☐ Health Care
☐ Medical	☐ Medical	☐ Medical
☐ Dental	☐ Dental	☐ Dental
☐ Vision	☐ Vision	☐ Vision
☐ Prescription	☐ Prescription	☐ Prescription
☐ Dependent Care	☐ Dependent Care	☐ Dependent Care
☐ Individual Health Premiums	☐ Individual Health Premiums	☐ Individual Health Premiums
Provider of Service	**Provider of Service**	**Provider of Service**
Name ________	Name ________	Name ________
Address ________	Address ________	Address ________
Dates of Service	**Dates of Service**	**Dates of Service**
From ____ To ____	From ____ To ____	From ____ To ____
Claim Type (check one)	**Claim Type (check one)**	**Claim Type (check one)**
☐ Proof of Credit/Debit Card Expense	☐ Proof of Credit/Debit Card Expense	☐ Proof of Credit/Debit Card Expense
☐ Request for Reimbursement	☐ Request for Reimbursement	☐ Request for Reimbursement
Claim Amount: ________	**Claim Amount:** ________	**Claim Amount:** ________
Proof of Expense * (check one)	**Proof of Expense * (check one)**	**Proof of Expense * (check one)**
☐ Explanation of Benefits (EOB) from Insurer	☐ Explanation of Benefits (EOB) from Insurer	☐ Explanation of Benefits (EOB) from Insurer
☐ Itemized bill showing service dates	☐ Itemized bill showing service dates	☐ Itemized bill showing service dates
☐ Statement from Dependent Care Provider	☐ Statement from Dependent Care Provider	☐ Statement from Dependent Care Provider
☐ Other proof of Claim (explain)	☐ Other proof of Claim (explain)	☐ Other proof of Claim (explain)

* Always retain copies of any proof of expense submitted with this claim form.

To the best of my knowledge and belief, my statements in this claim form are complete and true. All reimbursements from the plan are being claimed only for eligible expenses incurred by the above named person(s). I certify that these expenses have not been and will not be reimbursed under any other employer sponsored benefit plan and will not be claimed as an income tax deduction. I further certify that these expenses have not been previously reimbursed under this plan. Lastly, if my request for reimbursement can be claimed against multiple accounts, I agree that the order of accounts it is applied against, and reimbursed from, will follow the order defined in my employer's plan documents.

Employee's Signature: ________________________ Date: ____________

Mail, Submit Online via myRSC.com, or fax your Claim Form and Proof of Expense to:

Superior State Employer Solutions: PO Box 577 Menominee, MI 49858 ---- Fax: (906) 863-1105