

Number of pages faxed **CONTINUON SERVICES, LLC**Attn: FSA Administration
P.O. Box 7127 Atlanta, GA 30357-7127**FAX:** Toll free 1-866-593-7125**EMAIL:** fsa@csllc.com**PHONE:** Toll free (866) 377-5102 Option 2

Reimbursement Request Form

SECTION A- EMPLOYEE INFORMATION

Employee Name _____

Mailing Address _____

City, State, Zip _____

Daytime Phone # _____

Email Address _____

Is this a new address (check one) ☐ Yes ☐ No*If you have an address change, be sure to update your records with your employer.*

Social Security xxx-xx _____

Employer/
Former Employer: _____

SECTION B-EXPENSE TO BE SUBMITTED

This claim is to be applied to a preexisting ineligible ICUBA MasterCard transaction☐ Yes ☐ No

Complete the information below for expenses incurred by you, your spouse or dependent children for which you request reimbursement. You must provide receipts or other evidence of the incurred expenses. Be sure to provide all information requested on this form. Please send photocopies of forms and documents, keep originals for your records.

You can also file your claim online on our secure site at <http://icubabenefits.org>, upload your documentation directly to the site or print a confirmation sheet and fax or email it to us along with your supporting documentation.

Provider of Service	Person Receiving Service (Name and Age)	Dates of Service (from-to) Format dates: mm/dd/yy	Nature of Expense	Amount of Expense

Reimbursement for DCSA: Day Care Provider's Tax ID # (Signature and SSN if individual)

Tax ID # _____

\$ _____

TOTAL amount to be
reimbursed

SECTION C-EMPLOYEE CERTIFICATION

I request payment for my health care expense or dependent day care expense account as indicated above for the expense listed. To the best of my knowledge and belief, my statements in this reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred during the plan year or applicable grace period for me and my eligible dependents. I certify that these expenses have not and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HCSA/DCSA/HRA to reimburse me by the amount requested.

**SIGN AND DATE
FORM EACH TIME**

SIGN > SIGN > SIGN

I certify this claim in accordance with Section C-Employee Certification. Unsigned claim forms will result in automatic claim denial.

Participant Signature _____ Date _____