Flexible Spending Account Claim Form

Do not use for expenses already paid with your FSA card

Name of Employer:

Telephone Number:
(   )

Employee's Name:

Total Health Care Reimbursement Requested:
$

Email Address:

Total Dependent Care Reimbursement Requested:
$

Social Security Number:

Dependent Care Tax ID:

Mailing Address:

Date of Service	Provider Name	Description	Amount
			$
			$
			$
			$
			$
			$
			$

The under signed Employee certifies that all expenses hereby submitted are from services incurred during the current plan year

Signature:_______________________ Date:_______________

PLEASE ATTACH ALL RECEIPTS AND PROOF OF EXPENSES TO THIS FORM!

Mail to: Section 125 Claims Department
Paragon Benefits, Inc.
P.O. Box 12288 Columbus, GA 31917

Fax to: 706-256-4023
Email to: flex@paragonbenefits.com
For Claims Inquiries Call: 1.866.661.5078