J.J. STANIS & COMPANY, INC.

J.J. STANIS AND COMPANY, INC
377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530
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Request for Healthcare Reimbursement Expenses

Return completed form by Mail, E-mail: claims1@jjstanisco.com, or Fax

Employer _____ Group Number _____

Employee Name _____ Member ID # _____
Last Middle First

Home Address _____
Number/Street City State Zip

☐ Please check only if this is a new address. Daytime Telephone Number _____

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Check the box that applies. Supporting documentation as required by the IRS, applicable laws and/or your Plan must accompany this reimbursement request form.

- ☐ **I have group health (medical, dental, vision) insurance for this expense.** Attach a copy of the Explanation of Benefits (EOB) statement that you received from your insurance carrier showing how benefits were paid.
- ☐ **I do NOT have insurance coverage for this expense.** Submit an itemized statement showing the date of service, provider's name, services provided, and the amount of the charge.
- ☐ **I belong to an HMO.** Submit a paid receipt for your co-payments. For expenses not covered, submit an itemized statement.
- ☐ **I am submitting expenses for orthodontia.** With your first request, submit a copy of the Truth in Lending Statement (contract) itemizing the treatment period, down payment and monthly payments, and the amount covered by insurance, if any. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment.

Date of Service	For the Benefit of (Name and Relationship)	Description of Service	Provider of Service	Requested Amount

Total Requested Amount:_____

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

Employee Signature: _____ Date: _____

If you have questions about a claim, or the FSA program, please call **(877) 470-3715** between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.