Health Care FSA Claim Form

MAIL:
PO BOX 7500
CHAMPAIGN, IL
61826-7500

PHONE:
217-531-9000
877-272-8880

FAX:
217-239-4499
800-295-2990

ONLINE:
www.bpcinc.com

Employer: Bloomington Public Schools District 87

Participant Name (please print): _____ SSN: XXX-XX- _____

Day Time Phone Number: _____ Email Address: _____

☐ I have Changed My Address To: _____

Street City State Zip

NOTE: Please do not send original documentation to BPC. All items submitted (receipts and otherwise) will be considered property of BPC and will not be returned to you. The IRS has determined that cancelled checks, check carbons, balance forward or previous balance statements, as well as charge card receipts or statements are NOT acceptable documentation of expenses. Expenses MUST have been incurred during the coverage period. All submitted bills/receipts/statement/EOB must be itemized with the date of service, service provided/or item purchased, and the amount charged. All supporting documentation MUST be included with this form. Your claim will not be processed until these items are received.

FSA*	Expense Description	Dates of Service (from - to)	Provider	Claimant	Amount of Purchase
					$
					$
					$
					$
					$
					$
					$
					$
					$
				Amount Requested:	$

*A check will not be issued until **$25.00** in eligible claims have been received.*

I have included supporting documentation from an independent third party verifying that the eligible expenses has been incurred in the amount of the listed expense. By my signature below, I certify that all of the expenses listed on this form are valid and eligible and have been incurred by myself and/or my spouse and/or my eligible dependents. The expense(s) has/have not been reimbursed and I will not seek reimbursement under any other plan covering health benefits. I understand that the expense(s) for which I am reimbursed may not be used as deductions or credits on my, or my spouse's, income tax return. If I have inadvertently received payment for an ineligible expense or have been incorrectly reimbursed, I agree to provide repayment to the Plan.

A signature is required on each claim form that is submitted.

Participant Signature: _____ Date Submitted: _____

SUBMIT YOUR CLAIMS
bpcinc.com/claims

YOUR EMPLOYER PORTAL
bpcinc.com/clients/district87.cfm

CONTACT YOUR SPECIALIST
bpcinc.com/contact