FSA Reimbursement Request Form

This form allows you to request reimbursement from your Health FSA (Limited or Full Purpose).

INSTRUCTIONS: INCLUDE RECEIPTS AND DOCUMENTATION WITH THIS REQUEST FORM

Before completing this form, consider securely posting your claim using the online claim entry feature available on Igoe's Participant Portal or via IgoeMobile. If you are unable to use these secure tools, you can use this form by following the below steps:

1. **Fill** in all requested information and **attach** all supporting documentation if applicable:
   - All itemized bills and/or premium statements.
   - Explanation of Benefits.
   - Statement of service.
   - Receipts for expenses incurred.
2. **If you are unable to attach your form or document to an online or mobile app claim or alert**, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:
   - Email to claims@goigoe.com.
   - Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480.
3. **Questions?** Please contact Member Advocacy at claims@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Expenses Incurred (for participant and all federal tax dependents)

Clear Section B

Service Date (mm/dd/yy)	Name of Doctor / Provider of Services	Description of Expense	Person Incurring Expense Name, Age, Relationship	Net Amount
				$
				$
				$
				$
			Total Out of Pocket	**$** 0.00

Section C: Authorization *REQUIRED (PLEASE SIGN AND DATE)

I certify that I am a participant in the plan from which I am requesting reimbursement and that all expenses listed with this claim were incurred during my active participation in said plan. I certify that these expenses have not been and will not be reimbursed under any other benefit plan or charged to my employer's Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information herein. I further acknowledge that each expense listed above must be a proper expense under the plan. If not, I understand that I may be liable for the payment of all related taxes including federal, state or city Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE. Having agreed to all of the proceeding statements, I authorize the account associated with the plan selected to be reduced by the amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

Signature: Ready To Sign? Click To Print _____ ***Date:*** _____

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