



# SISC Flex Card and Health Care Claim Form

In many cases, if you used your SISC Flex Card at a participating IIAS merchant, your purchases may be automatically substantiated, therefore you may not need to complete this form. Refer to the SISC website for a list of participating IIAS merchants: <http://sisc.kern.org/flex/>

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ School District: \_\_\_\_\_

Type of Transaction:

**SISC Flex Card** (Verification of expense charged to my SISC Flex account.) **Claim Amount \$** \_\_\_\_\_  
▶ *SISC Flex Card documentation must be received by the SISC Flex office within 40 days after purchase or card privileges will be suspended.*

**Manual Claim** (Request reimbursement for out-of-pocket expense.) **Claim Amount \$** \_\_\_\_\_  
▶ *Please circle the item(s) you are claiming on the receipt or statement.*

**Employee's Certification:** *I certify that the attached expense(s) were incurred by me (and/or my spouse or eligible dependents), and were not reimbursed by any other plan, and are not for general health or cosmetic purposes. To the best of my knowledge and belief, request for repayment of out-of-pocket expenses are eligible for reimbursement under my SISC Health FSA plan. I (or we) will not use the expense claimed through this account as credits or deductions when filing my (our) individual income tax return. Further, I understand that I have 90 days (run-out period) following the end of the plan year to file claims for the current year. Expenses for all claims must be incurred during the current plan year, or the grace period (2 1/2 months following the plan year-end) associated with that plan year. If there is a question regarding eligibility of expenses or the dependency status, SISC may request additional information. All claims and supporting documentation must be received by the SISC office no later than March 31<sup>st</sup>.*

*Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail Claim Form and Supporting Documentation to:  
SISC Flex, P.O. Box 1808, Bakersfield CA 93303-1808 ♦ Or FAX to (661) 636-4063**

**Eligible reimbursements will be paid by check and mailed to your home address, or directly deposited to your bank account when authorized. Please notify SISC of any change in address as soon as possible.**

**Please retain a copy of the claim form and supporting documentation for your records.**

**SUPPORTING DOCUMENTATION MUST ACCOMPANY ALL CLAIM FORMS**

- ▶ For **prescription drugs**, attach a legible receipt from the service provider, which includes the date prescription was purchased, the drug name and prescription number, or the Rx label, the amount of purchase, and the name of the pharmacy. The Rx ticket typically contains this information.
- ▶ For **medical, dental, vision and other health care expenses**, documentation must include a legible copy of the provider's itemized statement of the charges including: 1) Provider's name and address; 2) Date of service or purchase; 3) Description of service or product; and 4) Amount charged for service or product. A copy of the Explanation of Benefits (EOB) is acceptable and preferred.
- ▶ For **over-the-counter medications**, purchases must be clearly defined on the receipt. The IRS ruling states that employees seeking reimbursement for nonprescription medications **must** present a receipt of purchase indicating: 1) Date of purchase; 2) Amount; and 3) Name of the product. If the item you are claiming is abbreviated on your receipt, you must attach a photocopy of the package label showing the full product description. We are unable to approve any item that is submitted with insufficient documentation. **When using your SISC Flex Card, please purchase your qualified over-the-counter medications separately from ineligible expenses.** Refer to our website for a list of eligible expenses.

*For SISC Use Only*

Authorization \_\_\_\_\_ Date \_\_\_\_\_ SF Approved \_\_\_\_\_ SF Pending \_\_\_\_\_ SF Denied \_\_\_\_\_

Reimbursement Approved \_\_\_\_\_ Reimbursement Denied \_\_\_\_\_ Claim # \_\_\_\_\_

Explanation: \_\_\_\_\_