AWM - Claim Form – Health FSA Reimbursement

☐ *Please check here if new mailing address* ☐ *Please check here if new email address*

Employer Name (Please Print) _____

Employee Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

Service Date (mm/dd/yyyy)	Patient Name	Description of Service	Amount
			$
			$
			$
			$
			$
			$
		Total	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature _____ Date ____/____/____
mm/dd/yy

For fastest reimbursement, please submit claims via secure fax, participant portal or email
F 855.265.1830 - support@awm.cc - awm.summitfor.me

Reimbursement Account Employee Direct Deposit Authorization Form

Instructions for Completing This Form:

1. Fill in all fields below
2. Attach voided check (no deposit slips)
3. Sign and date form.
4. If the account is not in your name alone, the other account holder must also sign and date form.

Employer Name (please print) _____

Last Name (Please Print) _____ First Name _____ Middle Initial ____

Address _____ City _____ State _____ Zip _____

E-mail Address _____

Social Security Number _____ Home Phone (_____)_____ Work Phone (_____)_____

Check Action: ☐ New ☐ Change ☐ Cancel Effective Date _____/_____/_____ Account Type: ☐ Checking ☐ Savings
mm/dd/yy

Ownership of Account: ☐ Self ☐ Joint ☐ Other _____

Name of Bank _____

Routing Transit Number
(All nine boxes must be filled)

☐☐☐☐☐☐☐☐☐

Account Number
(Include hyphens, but not spaces and special symbols)

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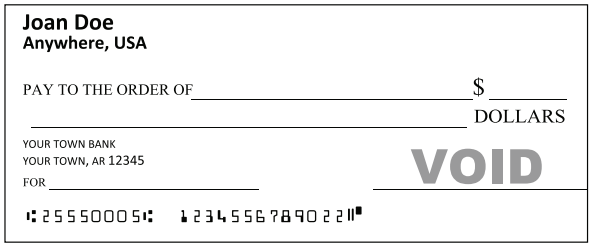
ATTACH A COPY OF VOIDED CHECK HERE

Do not attach deposit slips, as they do not supply the necessary information.



By signing this agreement, I authorize my benefits TPA to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature _____ **Date** _____/_____/_____
mm/dd/yy

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