Medical Flexible Spending Account (MFSA) Expense Affidavit

Name of Plan Participating Employee________________________________

Participating Employee's Identifying Number____________________________

Plan Sponsoring Employer **Collinsville Unit 10 School District**

Number of Items Attached _____ Total Dollar Amount Requested $__________

Instructions for submitting your claim for **MFSA** benefits:

- Fully complete, sign and date this affidavit
- Attach your expense items behind this affidavit, and mail to: OLB Systems 3440 Illinois Avenue, St. Louis, MO 63118
  Or fax your claim to: 314.664.2262
  Or scan your claim (.pdf format only), naming the file with your last name and the submission date and email to: olbsys@sbcglobal.net
- Do not submit cancelled checks, credit card vouchers or balance due statements – none of which are acceptable as expense verification
- Do not submit expense items which are payable by insurance or pending insurance adjudication – if in doubt, submit such items to insurance first
- If you are claiming non-Rx medications for reimbursement, you must submit a letter from your physician along with your receipts.

Expense items *must be as issued by the provider of services or insurance company* and must indicate:

- The name of the provider
- The name of the person receiving services
- Description of the services
- The dates of service
- The total dollar amount charged for services, and your out-of-pocket obligation, if less than the total charge

Benefits cannot exceed your annual **MFSA** election limit and cannot be assigned. By your signature below, you attest that the items submitted are not payable by insurance or *any other* benefit plan. You also attest that expenses reimbursed via the MFSA cannot be further claimed for income tax deduction.

Signature of Plan Participating Employee______________________________

Date_____________