Chard Snyder helps you get the most out of your FSA benefit.

Submit a Paper Claim Form

If you are submitting a paper claim for services you have received or purchases you have made, follow the steps below.

1. **Complete** the Flexible Spending Account (FSA) Claim Reimbursement Form available under *Tools & Support* in the Chard Snyder portal
2. **Make** a copy of your completed claim form and send it with a copy of your receipt or EOB
3. **Fax:** 513-459-9947 or 888-245-8452
4. **Mail:** Chard Snyder, PO Box 2924 Fargo, ND 58108-2924

When Your Reimbursement Should Arrive

Your check will arrive based on your employer's payment schedule, usually within about two weeks.

If you request reimbursement by check and your approved payment is less than $25, we will wait to send reimbursement until we receive additional claims that make your total reimbursement amount at least $25. If we don't receive any additional claims, we will send your reimbursement at the end of your plan's runout period. There is no minimum amount required for reimbursement by direct deposit.

Sign Up for Direct Deposit for Fastest Repayment

You may choose to have your reimbursement deposited directly into your personal bank account when you submit a claim for reimbursement:

1. **Log** in to your Chard Snyder online account
2. **Select** the *Tools & Support* tab
3. **Under** the *How Do I?* section, select *Change Payment Method*
4. **Under** *Current Payment Method,* select *Update*
5. **Select** *Direct Deposit* under *Alternate Payment Method* and *Submit*
6. If you have not previously added your bank account information, the *Add Bank Account Page* will display. Enter your information and *Submit*.

Chard Snyder Website

www.chard-snyder.com

Once you've enrolled, access your Chard Snyder FSA online account from the website home page by clicking on the blue *Login* tab at the top right of the page.

Chard Snyder Participant Services

Our Participant Services team is here to help answer questions you may have about your FSA. Contact us via Live Chat on the Chard Snyder website or give us a call.

CHARDSNYDER™
Benefit Solutions

800.982.7715 www.chard-snyder.com

CHARDSNYDER™
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Flexible Spending Account (FSA)
Claim Reimbursement Request Form

Submit a claim on your Chard Snyder online account or on the Chard Snyder Mobile App for quickest processing and reimbursement. Paper claims can be submitted by fax or mail, but expect longer processing times for these methods.

Company Information (PLEASE PRINT)	
Company Name	Division (if applicable)

Participant Information (PLEASE PRINT)			
Last Name		Primary Phone	
First Name		Secondary Phone	
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address (For Account Notifications)	
Street Address			
City		State	Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Dependent Name	**Relationship**	**Date of Birth**

Reimbursement Request (PLEASE PRINT)

Please indicate your eligible expenses below. **DO NOT include expenses reimbursed by any other source.**

HEALTH FSA

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From	through	**TOTAL Health FSA Reimbursement Request**
Description (Please list a brief description of services below – ie: Prescription, copay, contact solution, etc…)			$_____
IMPORTANT: If this is a Limited-Purpose FSA - Submit claims only for dental and/or vision expenses			**(REQUIRED)**

DEPENDENT CARE FSA

The following information is REQUIRED: Business name; dates of service and the expense amount; either a receipt/bill OR your provider's signature below. NOTE: Cancelled checks are acceptable for dependent care expenses only; credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From	through	**TOTAL Dependent Care Reimbursement Request**
Provider's Tax ID or SSN	**Provider's Business or Name**		$_____
Dependent Care Provider's Signature:		Date	**(REQUIRED)**

Claim Certification

To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my family member or I have received the services described above on the dates indicated and that the expenses qualify as valid medical expenses under the plan. I certify that these expenses have not been reimbursed under any other plan, nor will I seek reimbursement for any of these expenses elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **Any person who, with intent to defraud or knowing they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or healthcare fraud under state and/or federal law.**

Participant Signature (Required)	Date

SEND THIS FORM TO CHARD SNYDER

Please submit this form to Chard Snyder by one of the two methods listed to the right

Fax: Local 513.459.9947 / Toll-Free 888.245.8452 ***(Please DO NOT include a Fax Cover Page)***

Mail: PO Box 2924, Fargo, ND 58108-2924