Health Care Mileage Worksheet

flyte HUMAN CAPITAL MANAGEMENT

When submitting claims for a Health Flexible Spending Account (Health FSA) for mileage, this form must be forwarded to Flyte HCM along with a completed *Benefit Plan Claim Form* or submitted through https://flytehcm.lh1ondemand.com or the Flyte HCM Benefits Mobile App. If you are a Health Savings Account (HSA) accountholder tracking this information for your records to request a distribution, you do not need to submit this form to Flyte HCM. Please contact Flyte HCM at claims@flytehcm.com or 952.746.0000 with any questions.

Member Information

First Name MI Last Name Social Security Number *(required)* Employer Name

Trip Information

Month ______ Day ______ Year ______ Odometer Readings End of Trip (Stop) ______ Less Beginning of Trip (Start) ______ Total Health Care Miles ______	Health Care Miles Traveled ______	Purpose of Trip: ______ ______ ______ ______
Month ______ Day ______ Year ______ Odometer Readings End of Trip (Stop) ______ Less Beginning of Trip (Start) ______ Total Health Care Miles ______	Health Care Miles Traveled ______	Purpose of Trip: ______ ______ ______ ______
Month ______ Day ______ Year ______ Odometer Readings End of Trip (Stop) ______ Less Beginning of Trip (Start) ______ Total Health Care Miles ______	Health Care Miles Traveled ______	Purpose of Trip: ______ ______ ______ ______
Month ______ Day ______ Year ______ Odometer Readings End of Trip (Stop) ______ Less Beginning of Trip (Start) ______ Total Health Care Miles ______	Health Care Miles Traveled ______	Purpose of Trip: ______ ______ ______ ______
Month ______ Day ______ Year ______ Odometer Readings End of Trip (Stop) ______ Less Beginning of Trip (Start) ______ Total Health Care Miles ______	Health Care Miles Traveled ______	Purpose of Trip: ______ ______ ______ ______

Total Health Care Miles ______

Reimbursement Rate (from table) x ______

TOTAL EXPENSES $ ______

Allowable Mileage Expenses

Effective Date	Per Mile Rate
1/1/2016	$0.19
1/1/2017	$0.17
1/1/2018	$0.18

Certification & Acknowledgement

I verify that I have incurred the above mileage expense(s) in accordance with IRS regulations. The trip(s) listed were made specifically for health care, dental, and/or vision-related needs for myself, spouse, and/or dependents.

Signature of Member *Please be advised - unsigned forms cannot be processed.* Date