Benefit Plan Claim Form

For real-time claims submission without the claim form, please log into https://flytehcm.lh1ondemand.com or use the Flyte HCM Benefits Mobile App and enter your claims directly into the system. Your claims will be immediately available for review through your account and will be processed much faster.

Complete and submit this *Benefit Plan Claim Form* to Flyte HCM with the appropriate documentation of your expenses. Keep a copy of the form and all supporting documentation for your personal records. **Failure to complete the form in its entirety will result in a delay in processing your claim. For specific documentation requirements for the benefit plan(s) in which you are enrolled, please log on to https://flytehcm.lh1ondemand.com and visit the "Tools & Support" tab for Plan Rules and *Claims Filing & Reimbursement Procedures Letter*.**

Member Information

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

ALL INFORMATION MUST BE FILLED OUT COMPLETELY. Please complete a separate line for each expense. Use additional forms if necessary. Writing "see attached" with documents attached will not be accepted. Credit card slips, canceled checks, balance forward, balance due, or payment on account statements are not acceptable documentation.

Eligible Expense Amount	Type of Service (Medical, Dental, Vision, Prescription, Dependent Care, or Parking)	File Under Plan (Health FSA, Dependent Care, HRA/105, Parking, MEC)	Service Dates (not date paid or billed)		Service Provider's Name (Tax ID or SSN is Required on Dependent Care Documentation)	Name of Person Receiving Service
$						
$						
$						
$						
$						
$						
$						
$						
$	**Total expenses included on this claim form** - *please submit additional form(s) if more lines are needed*					

Dependent Care Provider Certification *(required only if a statement is not provided)*

Provider Name	Federal ID # or SSN	Provider Signature	Date

Signature certifies that services for the dates listed above have been rendered and paid for. The claim(s) should be for the amount paid for services received during the specified date(s) of service, not the amount of the payroll deduction from your check.

Certification & Acknowledgement

Reimbursement will be made in accordance with all Plan guidelines and design. I understand that my claims will be applied to the benefits I am enrolled in according to my employer's Plan Design. The expenses were incurred by my eligible dependents and/or myself. I have not and do not expect to be reimbursed for these expenses by any other source. Reimbursement is being requested after all other benefit payments from all other available plans have been completed. These expenses will not be deducted on my individual income tax return. I accept responsibility for the proper treatment of benefits paid under the Plan with respect to eligibility, income tax reporting and liability.

Signature of Member *Please be advised - unsigned claim forms will not be processed.* **Date**

Submit form by: • Fax - **952.666.7454** • Email - **claims@flytehcm.com** • Mail - **Flyte HCM, PO Box 3260, Burnsville, MN 55337**

Keep copies of your claim form and documentation for your records. If you have an email address on file with Flyte HCM, you will receive an email confirmation when the claims below have been entered in the system. To check the status of your account/claims, update your email address, or other profile information, please visit https://flytehcm.lh1ondemand.com or use the Flyte HCM Benefits Mobile App. Claim forms are not required for online submittal.