



Reimbursement processed by

Principal Life Insurance Company
Des Moines, Iowa

FSA

Flexible Spending Account Request for Reimbursement

Please mail completed form to:
Principal Life Insurance Company
PO Box 39710
Colorado Springs, CO 80949-3910
Toll free Nationwide 1-877-FSA-4730
FAX 888-308-5270

Email Claims:
FSARceipts@exchange.principal.com

Directions for Completing Request Form

1. Complete **Statement of Employee** below.
2. Complete the **Eligible Expenses Section** on Page 2. Indicate the total amount submitted for reimbursement on the bottom line.
3. If you want reimbursement of all or part of a deductible **OR** copayment on a charge which has been received for payment under any medical, dental or vision plan, attach a copy of the explanation of benefits form and indicate in the REIMBURSEMENT REQUESTED column on Page 2 of this form how much you want considered for payment. For all other expenses, attach proof of expense(s) which includes provider's name, date and type of services provided. ***To guarantee payment, your claims must be received in the Service Center no later than 2 business days prior to the pay date.***
4. Please refer to your Summary Plan Description (SPD) for the day of the month your reimbursement will be made and for the minimum amount. All eligible expenses for active or terminated employees for current year must be received **by the deadline in the SPD.**
5. Access your FSA through the personal login section of the Principal Financial Group internet site, www.principal.com. This is a secure site so follow the automated process under PIN/Password Services to obtain your personal identification number (PIN).

NOTE: Always retain copies of your proof of expense.

Statement of Employee

Employee's name _____

Member ID number or Privacy ID number _____

current plan year prior plan year

Employee's address _____

Street

City

State

ZIP

Employee's employer _____

I, the undersigned, request reimbursement for the eligible expenses listed on Page 2 for myself and any eligible dependents. I certify these expenses are eligible for reimbursement under the Flexible Spending Account sponsored by my employer. I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not include them as itemized deductions or as a tax credit on my personal income tax returns.

These statements are true and complete to the best of my knowledge. Signature of employee Date

Please furnish a daytime telephone number in case we need to reach you. Email address

Eligible Expenses Section on Page 2

Eligible Expenses Section

<u>Eligible expenses</u>	<u>Patient and relationship to employee</u>	<u>Provider of service and date of service</u>	<u>Reimbursement requested</u>
Health Care			
1. Medical			\$
			\$
			\$
			\$
			\$
			\$
2. Dental/Vision			\$
			\$

Dependent Care
(child, spouse, parent) Dependent's name, age, and relationship to employee

Provider's and facility's name _____

Date of service provided _____	Cost of service	\$ _____
Date of service provided _____	Cost of service	\$ _____
Date of service provided _____	Cost of service	\$ _____
Date of service provided _____	Cost of service	\$ _____

Total dependent care amount submitted for reimbursement \$ _____

Dependent care provider's signature

Total amount submitted for reimbursement \$ _____