

**Do not use this form for services paid with an FSA debit card.** Proof of expenses must be attached. Bills, statements, or *Explanation of Benefits (EOB)* from medical plans are required proof of expenses. IMPORTANT! Cancelled checks and credit card receipts are **not** sufficient proof of expenses.

**Section 1: Employee Information. Please print legibly.**

Full Name as it appears on your FSA debit card		QualChoice ID No.		Social Security No.	
Street Address		City	State	Zip	Phone No.

**Health Care Expenses**

Please only report one (1) expense per block. Combining multiple expenses in one block may delay reimbursement. If expense was incurred for eligible dependent, indicate type of relationship. Use "C" for child, "S" for spouse or "O" for other.

Date of Service (MM/DD/YYYY)	Type of Service	<input type="checkbox"/> Dental <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Prescription		Amount \$ _____
Name of Provider/Merchant: _____				
Dependent Name	Relationship to Employee	Birthdate (MM/DD/YYYY)		

Date of Service (MM/DD/YYYY)	Type of Service	<input type="checkbox"/> Dental <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Prescription		Amount \$ _____
Name of Provider/Merchant: _____				
Dependent Name	Relationship to Employee	Birthdate (MM/DD/YYYY)		

Date of Service (MM/DD/YYYY)	Type of Service	<input type="checkbox"/> Dental <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Prescription		Amount \$ _____
Name of Provider/Merchant: _____				
Dependent Name	Relationship to Employee	Birthdate (MM/DD/YYYY)		

**Dependent Care Expenses (Daycare)**

Please only report one (1) expense per block. Combining multiple expenses in one block may delay reimbursement.

Date of Service (MM/DD/YYYY)	Dependent Care Provider: _____		Amount \$ _____
Dep. Care Provider Taxpayer ID or SSN	Dependent Name	Relationship to Employee	Birthdate (MM/DD/YYYY)

Date of Service (MM/DD/YYYY)	Dependent Care Provider: _____		Amount \$ _____
Dep. Care Provider Taxpayer ID or SSN	Dependent Name	Relationship to Employee	Birthdate (MM/DD/YYYY)

Date of Service (MM/DD/YYYY)	Dependent Care Provider: _____		Amount \$ _____
Dep. Care Provider Taxpayer ID or SSN	Dependent Name	Relationship to Employee	Birthdate (MM/DD/YYYY)

Check box if signed by Dependent Care Provider. Dependent Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Necessary only if receipt is **not** provided.

**SECTION II. Authorized Signature**

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I further certify that if the above expenses are not eligible, I will remit payment in the amount of the ineligible expense to the plan. Additionally, these expenses are not being claimed as tax deductions under the IRS code.

Employee Signature <b>x</b>	Date Signed (MM/DD/YYYY)
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Mail: QualChoice, ATTN: FSA Dept., P.O. Box 25610, Little Rock AR 72221 or Fax: 833.765.1963

## Statement of Non-Discrimination

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact QualChoice Customer Service at 501-228-7111 (TTY: 711).

If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: QualChoice Civil Rights Coordinator, P.O. Box 25610, Little Rock, AR 72221, 501-228-7111 (TTY: 711), Fax 833-744-1736, QCA\_COE@qualchoice.com. You can file a grievance by mail, fax, or email. If you need help filing a grievance, QualChoice is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Declaración de no discriminación

QualChoice cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. QualChoice no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

### QualChoice:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
  - Intérpretes calificados de lenguaje por señas
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con QualChoice Customer Service a 501-228-7111 (TTY: 711).

Si considera que QualChoice no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: QualChoice Civil Rights Coordinator, P.O. Box 25610, Little Rock, AR 72221, 501-228-7111 (TTY: 711), Fax 833-744-1736, QCA\_COE@qualchoice.com. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, QualChoice está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government:

**ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).**

**Spanish**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

**Vietnamese**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

**Marshallese**

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbāl in jipañ ilo kajin ñe aṃ ejjelōk wōñāān. Kaalōk 1-800-235-7111 (TTY: 711).

**Chinese**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711)。

**Lao**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ຈຶ່ງຮ້າງ, ຈຶ່ງມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

**Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

**Arabic**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقم هاتف الصم والبكم: 711).

**German**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

**French**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

**Hmong**

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

**Korean**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

**Portuguese**

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

**Japanese**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711)まで、お電話にてご連絡ください。

**Hindi**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

**Gujarati**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).