AMERICAN BENEFITS GROUP

LIMITED PURPOSE / POST DEDUCTIBLE FSA REIMBURSEMENT

Please make copies and save for future claims filing

Name: _____ Last four digits of SSN: _____

Employer: _____ Email: _____

Your Limited Purpose/Post Deductible Health Care Flexible Spending Account can only be used to reimburse vision and dental expenses until you have incurred the federally mandated amount of deductible expenses ($1,650 if you are enrolled FOR 2025 in a single HDHP, or $3,300 if you are enrolled in a family HDHP). Once you have reached the federally mandated deductible, you may use the funds in your Limited Purpose/Post Deductible Heatlh Care Flexible Spending Account to be reimbursed for General Purpose FSA medical expenses incurred after the date you reached the deductible.

PLEASE NOTE: your **ABG Benefits Card** will only work for dental and vision expenses, claims for health care expenses will need to be filed manually.

In order to qualify for reimbursements from your post deductible FSA, you must submit an Explanation of Benefits (EOB) showing that you have reached the requisite federal deductible. All General Purpose FSA expenses submitted for reimbursement must have been incurred after the date you reached the federal deductible.

Limited Purpose/Post Deductible Claims (for you and/or your eligible dependents)

Please check the coverage level of your High Deductible Health Plan (HDHP): ☐ Single ☐ Family

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred	**LPF or Post Deductible FSA**	Amount Incurred
				TOTAL MEDICAL EXPENSE CLAIM	$

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relates to such expense.

Employee's Signature: _____ Date: _____

Please submit this claim form along with substantiating receipts or statements
(Receipts must indicate the dates of service, the name of the provider,
the nature of the service rendered or product purchased,
the person for whom the service was provided and the cost of the service)

Fax Toll Free to 877-723-0147 or email to claims@amben.com

No Fax or Email? Mail to: American Benefits Group,
PO Box 1209, Northampton, MA 01061-1209