



# My Reimbursement Plan Claim Filing Guide

## Welcome

We look forward to working with you as claims administrator for your flexible spending account program. If you have questions, need additional information or would like to discuss your reimbursement accounts in more detail, please contact our customer service department at (877) 289-0448.

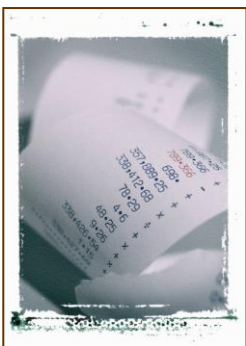
The claim filing instructions provide detail on how to file for reimbursement. Copies of all these materials can be viewed and printed from the flexible spending account plan web page.

## Frequency of reimbursement checks:

Please refer to your Flex Plan Highlight Sheet for information related to frequency of reimbursement payments. Please allow seven to ten business days for processing of your claim after receipt of claim.

## How to file a claim:

Complete a Flex claim form (include your employer's name, your name, social security number, list of eligible expenses and sign & date).



Attach all corresponding receipts and/or EOBs (must include the following):

- Merchants name
- Date of purchase
- Product name
- Amount paid

## Where to file claims:

Fax claims to: (216) 642-4863

### Mail claims to:

Vantage Financial Group Plan Services, Inc.  
P.O. Box 318082  
Cleveland, OH 44131

Online claim submission: [www.vfgps.com](http://www.vfgps.com)

Email claims via secure website: [www.vfgps.com](http://www.vfgps.com)  
(Do not use [csflex@vanfin.com](mailto:csflex@vanfin.com).)

## Claim filing deadlines:

Please refer to your Flex Plan Highlight Sheet for information related to plan year rules and claim filing deadlines.

## Customer Service

If you have questions regarding your claims, how to file claims or need specific information regarding your Plan, please contact our customer service department Monday through Friday between 8:15 a.m. and 4:45 p.m., EST, at: (877) 289-0448 or email a representative at [csflex@vanfin.com](mailto:csflex@vanfin.com).

Check your account balance online at [www.vfgps.com](http://www.vfgps.com).



See your Plan Highlight Sheet for more details.

**IMPORTANT:**  
Save copies of all receipts!

## Stark County Schools C O G Plan Highlight Sheet

This Plan Highlight Sheet provides a quick reference to some of the most common information regarding your Flexible Spending Account(s). This information is also referenced throughout the Enrollment Handout provided to you during open enrollment and within the claim kit materials you will be receiving.

If you have any questions or need further assistance, please contact a member of the VFGPS, Inc. customer service team at 1-877-289-0448.

<b>Plan Year:</b>	January 1 <sup>st</sup> – December 31 <sup>st</sup>
<b>Eligibility Guidelines:</b>	Any employee who has satisfied the conditions for coverage under the group health plan.
<b>Waiting Period:</b>	Same as the group health plan.
<b>Benefit Options Available:</b>	Medical Flexible Spending Dependent Care Flexible Spending
<b>Plan Maximums:</b>	Medical Flexible Spending: \$3,500.00 Annually Dependent Care Flexible Spending: \$5,000.00 Annually
<b>Reimbursement Options:</b>	Check or Direct Deposit
<b>Reimbursement Schedule:</b>	1 <sup>st</sup> and 15 <sup>th</sup> of each month
<b>Claim Filing Deadline for Terminated Employee's:</b>	Claims must be submitted no later than 90 days after the end of the plan year. –Remember that the remaining contributions for your Medical Flexible Spending Account will be withheld from your final paycheck as you are responsible for the entire annual election amount.
<b>Claim Filing Deadline at the end of the plan year:</b>	Claims must be submitted no later than 90 days after the end of the plan year.
<b>Website and log on information:</b>	<a href="http://www.vfgps.com">www.vfgps.com</a>  User Name: flexplan      Password: flexplan
<b>Claim Submission:</b>	Mail: VFGPS, Inc. 6200 Rockside Road, Suite 100 P O Box 318082 Cleveland, OH 44131-8082  Fax: 1-216-642-4863  Email: Visit <a href="http://www.vfgps.com">www.vfgps.com</a> for more information (Do not use <a href="mailto:csflex@vanfin.com">csflex@vanfin.com</a> .)
<b>Customer Service:</b>	Phone: 1-877-289-0448 Email: <a href="mailto:csflex@vanfin.com">csflex@vanfin.com</a>

**NOTE:**

For any Over the Counter (OTC) Expenses, a copy of the original receipt must be submitted for reimbursement. The receipt must include the vendor/merchant name, date of purchase, product name and the amount paid for an item.

# Direct Deposit Authorization

Employee Name \_\_\_\_\_ Employee SSN \_\_\_\_\_

Employer \_\_\_\_\_

I hereby authorize **Vantage Financial Group Plan Services, Inc.** (Claims Administrator) to initiate credit and debit entries to my checking or saving account indicated below and the depository named below (Depository) to credit/debit the same to such account. **(check one):**

**Checking Account**

**Savings Account**

**Please see sample check below for help in identifying account and transit routing numbers:**

Account Number \_\_\_\_\_

Depository (Financial Institution) \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Bank ACH Transit Routing Number \_\_\_\_\_

This authority will remain in full force and effect until the Claims Administrator has received written notification from me of its termination in such time and in such manner as to afford the Claims Administrator a reasonable opportunity to act on it.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail to:** Vantage Financial Group Plan Services 6200 Rockside Road, Suite 100 Cleveland, OH 44131-8082 Attn. Flex Dept.

**Online:** [www.vfgps.com](http://www.vfgps.com) (see your Plan Highlight sheet for more information)

**Fax:** (216) 642-4863

**Secure Email:** [www.vfgps.com](http://www.vfgps.com) (Do not use [csflex@vanfin.com](mailto:csflex@vanfin.com).)

**\*\*An actual *voided check* must be attached\*\***  
**Tape or staple voided check here**

Please do not attach a deposit slip. If an actual check is not available to attach (i.e. some savings accounts) you are responsible for obtaining the correct ACH transit routing number from your financial institution.

**\*\* SAMPLE CHECK\*\***

<b>Sample Company</b> 6200 Rockside Road Cleveland, OH 44131	ABC Bank Main Office Cleveland, OH 44131	410	<u>6-101</u>	<b>90381</b>
<b>Pay</b> One Dollar and 00/100 cents	<b>Date</b> 04/01/01	<b>Amount</b> <b>\$1.00</b>		
<b>TO THE ORDER OF</b> Joseph Smith 1234 Main Street Cleveland, OH 44131	<b>ID: 000-00-0000</b>			
"" 90381""	':041001013':	70121395""		
*[ Check #]	[ Routing Transit #]	[ Account #]		

\*(Check # may be to right or left)



# Flexible Benefit Plan Claim Form

ACCOUNT HOLDER INFORMATION:
Name of Employer:
Employee Name:
Social Security Number:
Day Time Phone Number:

Please reimburse the following Medical and/or Dependent Care expenses as covered under the Flexible Spending Account Plan.

Dependent Care Flexible Spending Account Claims:			
<i>Name of Dependent(s)</i>	<i>Period Covered</i>	<i>Name, Address, &amp; Tax ID Number</i>	<i>Amount</i>
<b>Total Dependent Care Claim</b>			<b>\$</b>

Flexible Spending Accounts:				
<i>Date Expense Incurred</i>	<i>Name of Service Provider</i>	<i>Person For Whom Expense Incurred</i>	<i>Expense Description</i>	<i>Amount</i>
<b>Total Medical Claim</b>				<b>\$</b>

**A detailed receipt including the merchants name, date of purchase, product name and the amount paid for the item must accompany any claim.**

- You are responsible for determining the validity of each item to be reimbursed; it is not the responsibility of your Employer or the administration company.
- These items cannot be reimbursed under any other plan.
- Supporting documentation must be attached to validate all reimbursement requests.
- Documentation must be a copy of the bill, explanation of benefits (EOB) or receipt which provides date of service or date of purchase.
- For Over The Counter (OTC) expenses to be reimbursed you must submit a detailed receipt including the merchants name, date of purchase, product name and the amount paid for the item.
- Medical Care Expenses reimbursed by this Plan cannot be claimed as deductions on your personal income tax return.
- Child Care Expenses cannot be reimbursed in excess of \$5,000 per year. Child care expenses reimbursed by this Plan cannot be claimed as a credit on your personal income tax return.

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Fax to: 216-642-4863      Email via secure website: [www.vanfin.com](http://www.vanfin.com)  
 Mail to: Vantage Financial Group Flexible Benefits 6200 Rockside Road, Suite 100 P.O. Box 318082 Cleveland, OH 44131  
 Online claim submission: [www.vfgps.com](http://www.vfgps.com)  
 Email claims via secure website: [www.vfgps.com](http://www.vfgps.com)      (Do not use [csflex@vanfin.com](mailto:csflex@vanfin.com).)