Principal Financial Group

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 719-548-4003

Email Claims:
FSAReceipts@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.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Eligible expenses	Patient and relationship to employee	Provider of service and date of service	Reimbursement requested
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 $

Print