



**The Diocese of Long Island
Flexible Spending Account
Claim Form**

Benefit Analysis, Inc.

P.O. Box 527
Nutley, NJ 07110-0527

1. Participant Information and Signature

By submitting this claim form, I (participant named below) certify that I and/or my dependents incurred the below expenses, and that I have paid the expense(s) incurred by me and/or my eligible dependents. This reimbursement is not payable under any other plan. I further declare that I have not and will not deduct these expenses on my Federal and State income tax returns.

Participant Name (please print): _____ Social Security Number: _____

Participant Address: _____ City: _____ State: _____ Zip: _____

CHECK IF ABOVE IS A CHANGE OF HOME ADDRESS

How may we contact you during the day? Email: _____ Phone: _____

Participant Signature: _____ Date: _____

2. Dependent DAY Care FSA - attach all documentation **The child must be under the age of 13**

| Benefit Card? Y/N | Dependent Name | Age | Provider Name | Tax ID Number | Date(s) Of Service mm/dd/yyyy | | Requested Amount |
|-------------------|----------------|-----|---------------|---------------|-------------------------------|-----|------------------|
| | | | | | From: | To: | |
| | | | | | From: | To: | |
| | | | | | From: | To: | |
| | | | | | From: | To: | |
| | | | | | From: | To: | |
| | | | | | From: | To: | |
| | | | | | From: | To: | |
| | | | | | From: | To: | |

3. Health Care FSA - attach all documentation Total Amount Requested \$

| Benefit Card? Y/N | Patient Name | Provider Name | Description of Service | Date of Service | Requested Amount |
|-------------------|--------------|---------------|------------------------|-----------------|------------------|
| | | | | | |
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4. Process Total Amount Requested \$

For more efficient processing, submit the claim via BAI website portal at www.benefitanalysis.com

To submit by mail send to:
Benefit Analysis, Inc.

To submit by fax send to:
973-661-2888

To submit by email send to:
Info@benefitanalysis.com

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ONLY ONE METHOD OF SUBMISSION IS NECESSARY

SUBMISSION DEADLINE FOR ACTIVE EMPLOYEES

Employees have 90 days after the plan year end to submit claims for both Health (HCR) and Dependent Day Care (DCR).

SUBMISSION DEADLINE FOR TERMED EMPLOYEES

Termed employees have 90 days from the plan year end for HCR. The services provided must have been incurred while still an active employee. For DCR contact BAI.