

**LIMITED PURPOSE HEALTH CARE**

# FSA

Please mail completed form to:  
Nippon Life Insurance Company of America  
Attn: Claim Center (FSA)  
P.O. Box 2968  
Clinton, IA 52733  
Toll free Nationwide 1-800-374-1835  
FAX 1-866-514-8287  
E-mail – fsa-hra@nipponlifebenefits.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 information on when your reimbursement will be made and for the minimum amount required. All eligible expenses for active employees for current year must be received by the deadline in the SPD.
5. Access your FSA through the personal login section of the Nippon Life Insurance Company of America (NLI America) internet site, www.nlia.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 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. Applicable to Accident and Health.**

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.      Area code      Email address

**Eligible Expenses Section on Page 2**

**Eligible Expenses Section**

<u>Eligible expenses</u>	<u>Patient and relationship to employee</u>	<u>Provider of service and date of service</u>	<u>Reimbursement requested</u>
<b>1. Dental</b>	_____	_____	\$ _____
	_____	_____	\$ _____
	_____	_____	\$ _____
<b>2. Vision</b>	_____	_____	\$ _____
	_____	_____	\$ _____
	_____	_____	\$ _____

I certify that the following expenses meet the definition of preventative medical care as defined in section 223(c)(2)(C) and does not generally include any benefit or service intended to treat an *existing* illness, injury, or conditions.

Employee Signature: \_\_\_\_\_

<b>3. Preventive</b>	_____	_____	\$ _____
	_____	_____	\$ _____

## **Notice Requirements**

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Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

### **CALIFORNIA FRAUD**

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **COLORADO FRAUD**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

### **DISTRICT OF COLUMBIA FRAUD**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

### **FLORIDA FRAUD**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

### **INDIANA FRAUD**

A person who knowingly and with intent to defraud any insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

### **KENTUCKY FRAUD**

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

### **NEW JERSEY FRAUD**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

### **OHIO FRAUD**

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

### **PENNSYLVANIA FRAUD**

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 subjects such person to criminal and civil penalties.

### **TENNESSEE FRAUD**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**Notice Requirements (continued)**

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**TEXAS FRAUD**

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be guilty of insurance fraud.

**WASHINGTON FRAUD**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.