AMERICAN FIDELITY
a different opinion

Reimbursement Services | P.O. Box 25523 | Oklahoma City, OK 73125
American Fidelity Assurance Company | 800-662-1113 | Fax: 844-319-3668 | **americanfidelity.com**

Medical Travel Expense Reimbursement Claim Form

Name of Employee: (Last, First, MI)	
Social Security Number:	Email Address:
Mailing Address: (street, city, state, zip)_____	
Is this a new address? ☐ Yes ☐ No If yes, do you have any other American Fidelity benefits? ☐ Yes ☐ No	
Employer's Name:	Daytime Phone Number: (with area code)

Date of Travel	Patient's Name	Physician or Treatment Facility Location	Type of Treatment/ Diagnosis	Number of Miles	Total Reimbursement Amount*
			Expense Total: (must be completed)		

**Mileage rates vary year-to-year. Visit americanfidelity.com/hcfsa-help for mileage rates to be sure the dates of travel correspond with reimbursement amounts being requested.*

I certify that the medical travel expense(s) listed above was incurred for transportation primarily for and essential to medical care for myself or an eligible dependent. The medical care was provided by a physician in a licensed hospital or medical facility, and no element of personal pleasure, recreation, or vacation was involved in the travel. Travel to and from a pharmacy does not qualify as medical care and is not eligible for reimbursement.

I authorize the above expenses to be reimbursed from my account balance. To my knowledge, my statements on this form are accurate and complete. I certify that either I, my spouse, my tax dependent, or my adult child who will be under the age of 27 as of the end of the calendar year has received the services described above on the dates indicated and that the expenses qualify as valid "medical care expenses" as defined by Internal Revenue Code Section 213(d). I certify that these expenses have not been reimbursed under this or any other health plan, and I will not seek reimbursement under any other health plan. I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I understand I may be asked to provide further documentation or details about an expense.

Employee Signature: _____ Date: _____

Please return this form to:

Mail:
American Fidelity
P.O. Box 161968
Altamonte Springs, FL 32716

Fax:
844-319-3668

American Fidelity is not responsible for any faxes that are not received. The typical processing time for a Healthcare Flexible Spending Account is 5 to 7 business days from the date we receive a completed form. The processing time for a Health Reimbursement Arrangement may vary depending on your employer's plan.

If this form is incomplete, it could cause a delay in processing or lead to a denied claim. Please keep a copy of all submitted claims for your records.