

# CIGNA Choice Fund® Flexible Spending Account (FSA) Health Care Request for Reimbursement



REIMBURSEMENT TO BE ISSUED FROM: *(select one)*

FSA Healthcare     Limited Purpose FSA

IS THIS A CLAIM RESUBMISSION?

No     Yes (Claim Resubmission)

**FOR INTERNAL USE ONLY:  
CORR TYPE - HR**

## EMPLOYEE INFORMATION *(\*Indicates Required Information)*

CIGNA ID NUMBER OR SOCIAL SECURITY NUMBER *	LAST NAME*	FIRST NAME*	M.I.*
MAILING ADDRESS		CITY	STATE    ZIP CODE
		<input type="checkbox"/> Check if address is new	
DAYTIME TELEPHONE NUMBER	E-MAIL ADDRESS		
EMPLOYER NAME*		ACCOUNT NUMBER(S)*	

## PLAN COVERAGE INFORMATION

If an expense is covered by insurance, please submit to the appropriate carrier(s) first.  
If all information below is not completed, CIGNA will *only* reimburse items that we can determine to be qualified expenses (including associated tax and shipping charges).  
In order for timely processing, the following information *must* be filled out completely and accurately.

PATIENT NAME	PROVIDER NAME AND ADDRESS (i.e., Doctor Name/Pharmacy Name)	DATE(S) OF SERVICE	(A) TOTAL CHARGE	(B) AMOUNT PAID BY OTHER SOURCES (i.e., Other Insurance, Medicare, etc.)	(C) AMOUNT OF REQUEST (A - B = C)
TOTAL FROM NEXT PAGE <i>(if needed)</i> :					
SALES TAX AND SHIPPING CHARGES:					
TOTAL REIMBURSEMENT REQUEST:					

## CERTIFICATION

I certify that all expenses for which reimbursement is claimed from the CIGNA Flexible Spending Account have been incurred and have not been reimbursed and are not reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, an itemized receipt from a merchant or an Explanation of Benefits from a provider. I represent that any individual (other than the employee or employee's spouse) for whom a claim is filed hereunder, qualifies as a dependent of the employee for federal income tax purposes. I further declare that I have not and will not deduct these expenses on my federal, state or local income tax returns.

EMPLOYEE SIGNATURE <i>(Required)</i>	DATE
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**REMEMBER: Claim *must* be submitted with itemized receipts and/or EOBs. Please *do not* highlight items.**

**Please send completed form along with all required documentation to:** CIGNA HealthCare Choice Fund®  
P.O. Box 5200  
Scranton, PA 18505-5200  
Fax: 570.496.2945

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