# CIGNA Choice Fund® Flexible Spending Account (FSA)
## Over-the-Counter (OTC) and Prescription (Rx)
### Request for Reimbursement

**REIMBURSEMENT TO BE ISSUED FROM:**
- [ ] FSA Healthcare
- [ ] Limited Purpose FSA

**IS THIS A CLAIM RESUBMISSION?**
- [ ] No
- [ ] Yes (Claim Resubmission)

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**INSTRUCTIONS**

**THE FOLLOWING INFORMATION IS REQUIRED:**
1. DATE OF PURCHASE
2. FULL NAME OF EACH PRESCRIPTION AND/OR OVER-THE-COUNTER (OTC) ITEM PURCHASED
3. INTENDED USE OF ITEM (i.e., diagnosis) Example: Used to treat headache
4. AMOUNT REQUESTED FOR EACH ITEM
5. SALES TAX AND SHIPPING CHARGES, IF APPLICABLE
6. TOTAL REIMBURSEMENT REQUEST
7. SIGN CERTIFICATION

If all OTC information below is not completed, CIGNA will only reimburse items that we can determine to be qualified expenses (including associated tax and shipping charges).

**DATE OF PURCHASE OR IF RX, USE FILL DATE**

<table>
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<tr>
<th>OTC ITEM NAME AND/OR PRESCRIPTION NAME</th>
<th>INTENDED USE OF ITEM/DRUG (i.e., diagnosis)</th>
<th>AMOUNT OF REQUEST</th>
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**TOTAL FROM NEXT PAGE (If needed):**

**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, including the name of the product, the date purchased and amount paid. 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** (Required)

**DATE**

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**REMINDERS:**
- Claim must be submitted with itemized receipts.
- 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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