Debit Card Validation Form

Complete this form if you have used your CIGNA debit card and need to submit an expense receipt to CIGNA.

For details on how to complete the form and receipt instructions, see the back of this form.

FOR INTERNAL USE ONLY:
CORR CODE: SA

EMPLOYEE INFORMATION (*Indicates Required Field)				
CIGNA ID Number or Social Security Number:*	Last Name:*		First Name:*	M.I.
Mailing Address:	City:	State:	ZIP Code:	Check if Address is New ☐
Daytime Telephone Number:		Email Address:		
Employer Name:*		Account Number(s):*		
Amount:	**Date of Service:**	**Doctor/Hospital/Dentist Name:**	**Comments:**	
$				

I certify that I have purchased all the expenses/services I am claiming for reimbursement from the CIGNA Flexible Spending Account. I have not been reimbursed nor are these items/services reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, a complete receipt from a doctor, hospital or dentist. I attest that any claims I submit for any individual (other than me or my spouse) qualifies as a dependent of mine for federal income tax purposes. I further declare that I have not and will not deduct these expenses from my federal, state or local income tax returns.

EMPLOYEE SIGNATURE (REQUIRED)	**DATE**

If you have a recurring expense, you only have to submit this item for verification once. A recurring expense is a service or item you purchase often for the same dollar amount with the same doctor, hospital or dentist, such as refills on maintenance medications. For recurring expenses, please complete the following:

Merchant Name _____ Amount $ _____ Date of Last Charge ____/____/____

How to submit your purchases for validation:

Visit doctor or hospital and Use debit card → 1 Complete form for each claim → 2 Attach receipt → 3 Fax or mail to CIGNA

Fax your documents to **1.859.410.2424**. Or mail to the address below. Be sure to keep a copy for your records.

CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422-7223

CIGNA®

821233 c 11/10

Debit Card Validation Form Instructions

Please use black or blue ink to complete the form. Please print clearly and only in the spaces provided. This form will be processed electronically.

EMPLOYEE INFORMATION (*Indicates Required Field)

CIGNA ID Number or Social Security Number:*	Last Name:*	First Name:*	M.I.
012345678	Smith	Alan	R

Mailing Address:	City:	State:	ZIP Code:	Check if Address is New ☐
1234 Main Street	Anytown	US	12345	

Daytime Telephone Number: 555-222-1234	Email Address: alansmith@abccompany.com
Employer Name:* ABC Company	Account Number(s):* 1234567

Amount:	Date of Service:	Doctor/Hospital/Dentist Name:	Comments:
$ 43.25	1/21/10	Dr. Maxwell	Chiropractic Visit

SAMPLE

I certify that I have purchased all the expenses/services I am claiming for reimbursement from the CIGNA Flexible Spending Account. I have not been reimbursed nor are these items/services reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, a complete receipt from a doctor, hospital or dentist. I attest that any claims I submit for any individual (other than me or my spouse) qualifies as a dependent of mine for federal income tax purposes. I further declare that I have not and will not deduct these expenses from my federal, state or local income tax returns.

EMPLOYEE SIGNATURE (REQUIRED)	DATE
Alan Smith	2/15/10

If you have a recurring expense, you only have to submit this item for verification once. A recurring expense is a service or item you purchase often for the same dollar amount with the same doctor, hospital or dentist, such as refills on maintenance medications. For recurring expenses, please complete the following:

Merchant Name _____ Amount $ _____ Date of Last Charge ____/____/____

Complete and sign the Debit Card Validation Form. Write your name on the form as it appears on your CIGNA ID card. Attach a copy of your receipt. Keep original for your files. Credit card statements are not acceptable forms of receipts.

Make sure your receipt shows the following:

- Name and contact information for doctor, hospital or dentist
- Description of item or service
- Expense amount

Good Receipt

Dr. Maxwell, Chiropractor
(800) 999-9999
Patient: **ALAN SMITH**
Date of Visit: 1/21/2010
Chiropractic Visit Pay: $43.25
Dr. Maxwell 45 Main St. Anywhere, CT 00000

Important Notice

Remember, the Internal Revenue Service (IRS) regulations state that all purchases have to be verified using detailed receipts. Using your Debit Card doesn't reduce or eliminate the need to submit proof for eligibility. Many purchases will still need to be verified with detailed receipts or Explanation of Benefits (EOB). That's why you must always save your receipts for all items and services you purchase using your Debit Card.

"CIGNA" and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), CIGNA Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC.

821233 c 11/10 ©2010 CIGNA. Some content provided under license.