

Please **STAPLE** all documentation to the back of this form in this corner

Flexible Benefits Program Request for Reimbursement

This is a two page form. Be sure it has a back side

EMPLOYER NAME:

Please include an email address and/or phone number that we may contact you at if we have any questions regarding this claim.
() - and/or @

1 EMPLOYEE INFORMATION

Check here if this is a new address

Employee Name

Street Address

City, State, ZIP

SS# or ID #

2 CLAIM INFORMATION (See back side of this form for instructions)

This form must be filled out completely. Forms marked "see attached" will delay processing.

The Plan will reimburse you the maximum amount you are eligible for. Please inform us if you are specifically requesting a lesser amount.

Circle Account	Provider of Service	Covered Person	Date(s) of Service	Amount to be reimbursed	S=substantiate O=offset N=new claim
Medical Dependent Care					
Medical Dependent Care					
Medical Dependent Care					
Medical Dependent Care					
Medical Dependent Care					
Medical Dependent Care					

IF YOU ARE SUBSTANTIATING A PRIOR DEBIT CARD TRANSACTION OR OFFSETTING A PRIOR DEBIT CARD TRANSACTION, PLEASE INDICATE ABOVE. WRITE "S" if substantiating a previous debit card transaction without sending a copy of the substantiation request letter. Write "O" if offsetting a previous debit card transaction that was ineligible. WRITE "N" if this is a new claim.

3 SIGNATURE

I request payment from my Flexible Benefits Account(s) for the expenses itemized above. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I also certify that the total dependent care expense(s) (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that I have met all the requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature

Date