



Customized • Dedicated • Service

FLEXIBLE SPENDING ACCOUNT
Reimbursement Request Form

NAME:	Last	First	MI	SS#	
ADDRESS:	Street	City	State	ZIP	PHONE # ()

Please check if this is a new address

❖ Information below must be complete

MEDICAL EXPENSE CLAIMS					
Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
Total :					\$

DEPENDENT CARE CLAIMS						
Date of Service MM/DD/YY	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
						\$
						\$
Total:						\$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act, punishable under law.

Employee Signature: _____

Date: ____ / ____ / ____