Company Information (PLEASE PRINT)	
Company Name	Division (if applicable)

		ations)
Street Address		
City	State	Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Dependent Name	Relationship	Date of Birth

Reimbursement Request (PLEASE PRINT)

Please indicate your eligible expenses below. DO NOT include expenses reimbursed by any other source.

HEALTHCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From	through	TOTAL Healthcare Reimbursement Request
Description (Please list a brief description of services below – ie: Prescription, copay, contact solution, etc…)			$_____
IMPORTANT: If this is a Limited Healthcare Flexible Spending Account - Submit claims only for dental and/or vision expenses			(REQUIRED)

DEPENDENT DAYCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

The following information is REQUIRED: Business name; dates of service and the expense amount; either a receipt/bill OR your provider's signature below. NOTE: Cancelled checks are acceptable for daycare expenses only; credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services

Flexible Spending Account
Claim Reimbursement Instructions

Complete all company and employee information on the front page (please print/type). NOTE: Please include your e-mail address to receive an automatic e-mail notification whenever a claim is entered into our system and when a reimbursement is approved for you to receive payment

Attach supporting documentation. A copy of a receipt or EOB must accompany this request for each claim submitted for reimbursement. Each claim request must include the following information to be eligible for reimbursement:

- Original date of service (not the date you paid the provider)
- Description of the service performed (refer to list of eligible expenses to identify valid services)
- Provider's name and address (If submitting receipts for dependent daycare expenses)
- Amount charged to you (do not include amounts reimbursed or paid by another source)

Healthcare – Flexible Spending Account Reimbursement Request: Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as described above.

Dependent Daycare – Flexible Spending Account Reimbursement Request: Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as described above.