Flexible Spending Account Reimbursement Claim Form

FSA CLAIM REIMBURSEMENT REQUEST FORM - Receipts received with this form will be processed for reimbursement.

Do not use this form for submitting FSA DEBIT CARD PURCHASE RECEIPTS.

Name____ Home Phone (   )_____________________________________

Day Phone (   )__________________________________ Address____

City____ State___________________________________ Zip_________________________

Social Security No.____ Employer____

SUMMARY OF MEDICAL/ DEPENDENT CARE EXPENSES

Name of person receiving services	Relationship to employee	Provider of services*	Dates of service **	Amount to be reimbursed
Example: John Doe	***Self***	***Dr Smith***	***April 19, 2007***	***$20.00***

* "Provider" means hospital, doctor, dentist, drugstore, daycare, ect.
** Use date on which service was provided, not the date you paid for it.

I hereby certify that all items I requested comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person nor have these items been paid for by a debit card or stored value card offered with the Flexible Spending Account Plan. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year.

Employees Signature ____ **Date** ________________________

Fax or mail to:
Benecom Company
3429 Stony Spring Circle
Louisville, KY 40220
Office: 502-499-2501
Fax: 502-495-6825