



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
<i>Example: John Doe</i>	<i>Self</i>	<i>Dr Smith</i>	<i>April 19, 2007</i>	<i>\$20.00</i>

* "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
PO Box 20458
Louisville, KY 40250
Office: 502-499-2501
Fax: 502-495-6825