FLEXIBLE SPENDING ACCOUNT CLAIM FORM
REQUEST FOR REIMBURSEMENT

Please print. Complete all appropriate sections, sign, and return form and all documentation to:

Flex Spending Acct. Administrator
P.O. Box 159
Warren, MI 48090

1. EMPLOYEE INFORMATION **PLAN YEAR** ______

Name ______ Last 4 digits of SS # ______

Employer/Location ______ Phone ______ Ext. ______

2. HEALTH CARE REIMBURSEMENT (for self and dependents)
It is important that you attach the explanation of benefit statement from your insurance carrier as documentation for all medical and dental claims.

	Provider of Service	Date(s) of Service	Expense Code*	Amount Requested for Reimbursement
1.				
2.				
3.				
4.				

*Expense Codes: (M=Medical) (PD=Prescription Drugs) (D=Dental) (V=Vision)

Medical Insurance Name: ______ Dental Ins. Name: ______

Vision Insurance Name: ______

3. CHILD CARE REIMBURSEMENT

	Child Name & Relationship	Date of Service From	To	Age	Amount Requested for Reimbursement
1.					
2.					

Name and address of individual or institution to which Child Care expenses were paid.

Name: ______ Tax ID or SSN: ______

Address: ______

Signature of Caregiver (or signed receipt) ______________________________ Date: ___________

4. SIGNATURE AND DATE

I request payment from the reimbursement account for the expenses itemized above. I certify that I have not previously requested or received reimbursement under this plan or from any other source for these expenses. I also certify that the total child care expenses (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 certify that I have met all of the requirements for eligible health care and child care as described on the reverse of this form. I further certify that all services, health care, and/or child care were provided and paid for within the plan year. I understand that reimbursed expenses cannot be claimed on my personal income tax return.

Employee Signature: ______________________________ Date: ______________

FOR COMPANY USE ONLY:

Benefits Administrator	Date	Amount	Code	Employee No.