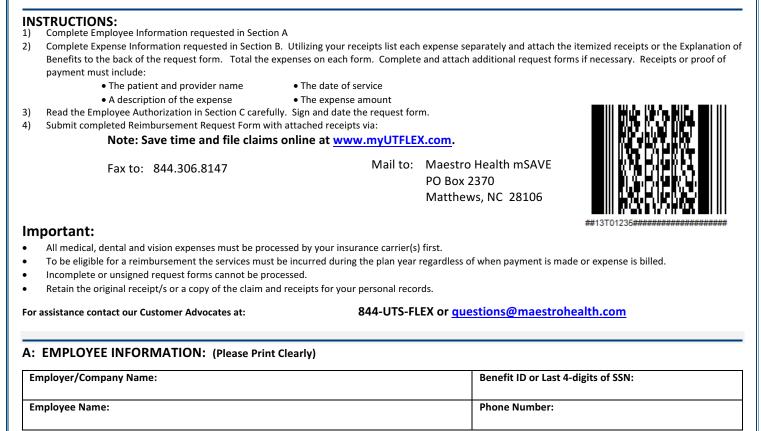


HEALTHCARE FSA REIMBURSEMENT REQUEST FORM



REIIVIDURSEIVIEINT



B: EXPENSE INFORMATION:

| Patient Name | Provider Name | Description of Expense (Itemize each expense on a separate line) | Date of Service (mm/dd/yyyy) | Expense Amount |
|--------------|---------------|---|---------------------------------|-------------------|
| | | Medical Dental Vision Prescription | | \$ |
| | | □ Over The Counter □ Other: | | |
| | | □ Medical □ Dental □ Vision □ Prescription | | \$ |
| | | Over The Counter Other: | | |
| | | □ Medical □ Dental □ Vision □ Prescription | | \$ |
| | | Over The Counter Other: | | |
| | | □ Medical □ Dental □ Vision □ Prescription | | \$ |
| | | Over The Counter Other: | | |
| | | □ Medical □ Dental □ Vision □ Prescription | | \$ |
| | | Over The Counter Other: | | |
| | | □ Medical □ Dental □ Vision □ Prescription | | \$ |
| | | Over The Counter Other: | | |
| | | Medical Dental Vision Prescription | | \$ |
| | | Over The Counter Other: | | |
| | | ТОТ | AL SUBMITTED: | \$ |

C: EMPLOYEE AUTHORIZATION:

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my Employer's Flexible Spending Account Plan and that these expenses have been incurred during the Plan Year. I further declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Flexible Spending Account.

Employee Signature