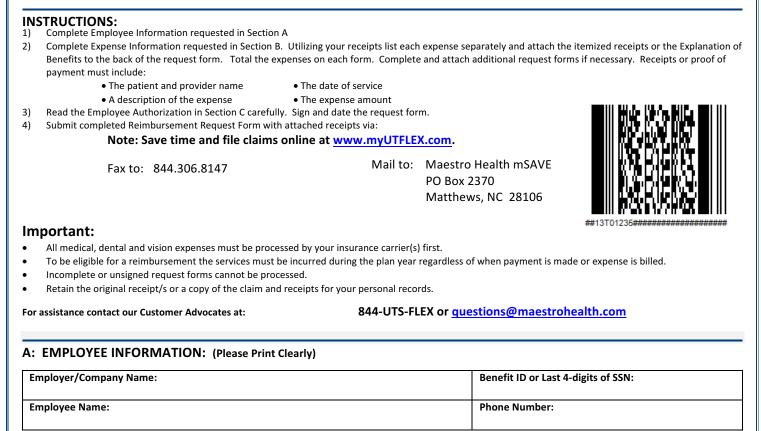


HEALTHCARE FSA REIMBURSEMENT REQUEST FORM



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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