Reimbursement Request Form

Flexible Spending Account

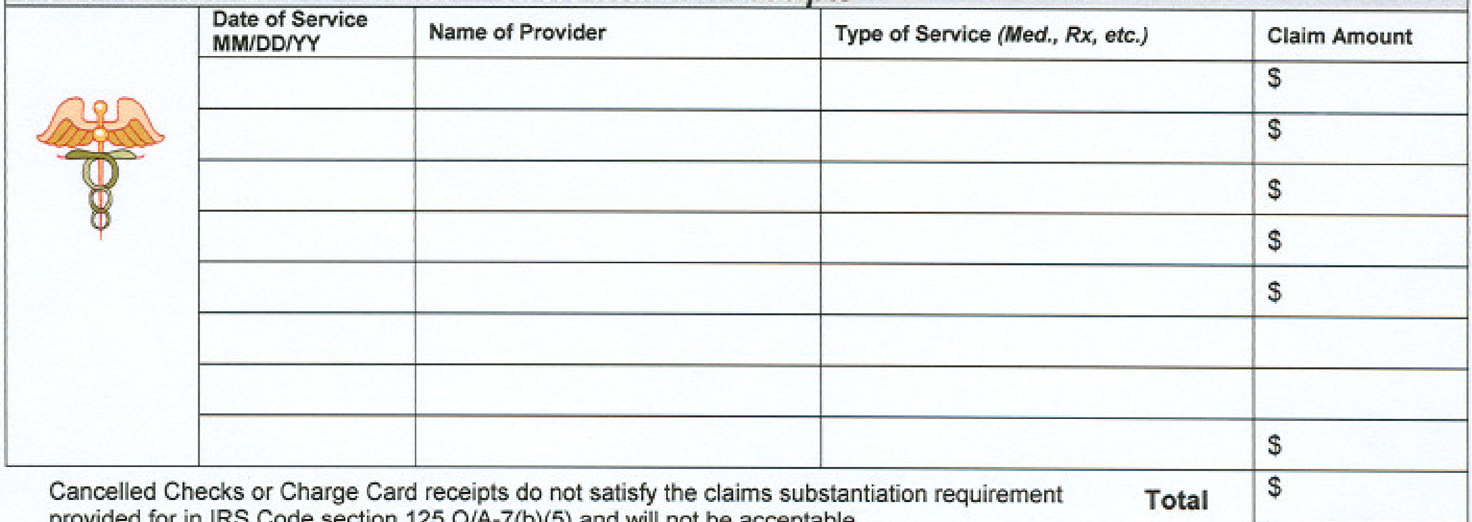
An expense is incurred when service is provided-
Not when you pay for it.

Employer Name:		**SS#:**	
Employee Name:		**Phone:**	( )

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim

*Information below must be completed

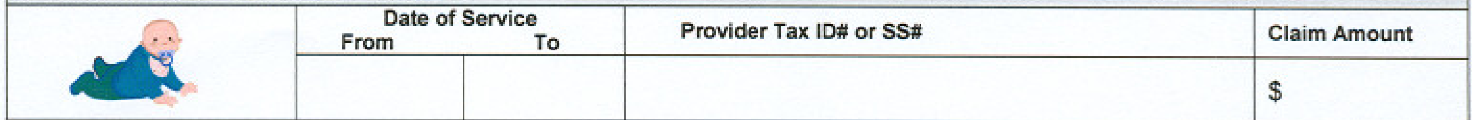
MEDICAL EXPENSE CLAIMS - *Circle items on receipts*



Date of Service MM/DD/YY	Name of Provider	Type of Service *(Med., Rx, etc.)*	Claim Amount
			$
			$
			$
			$
			$
			$
		Total	$

Cancelled Checks or Charge Card receipts do not satisfy the claims substantiation requirement provided for in IRS Code section 125 Q/A-7(b)(5) and will not be acceptable.

DEPENDENT CARE CLAIMS



Date of Service From	To	Provider Tax ID# or SS#	Claim Amount
			$

IMPORTANT: You are required to provide the name, address & taxpayer identification number or social security number of your dependent care provider when you file your income tax return on IRS form 2441. If you are unable to provide this, the deduction for Dependent Care FSA may be denied by IRS.

INDIVIDUALLY OWNED HEALTH INSURANCE CLAIMS

Premium Expense From	To	Name of Person Premium Covers	Insurance Carrier Name	Claim Amount
				$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Employee Signature:______________________________ Date_______/_______/_______

☐ Change of address:____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

FOR FASTEST REIMBURSEMENT, FAX TO: 405-616-0121

Or mail to: Worksite Benefit Plans, Inc., 8524 S. Western, Ste 106, Okla. City, OK 73139

Phone: 405-616-0122

(Update: 05/20/2005 V1.0)