

**GENERAL McLANE
FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT FORM**

- Include itemized bills, eligible receipts, or explanation of benefits. Dependent Care reimbursements require a statement or receipt from the provider confirming the amount of dependent care expenses including Tax I.D. number of the care provider.
- Mail or fax this form directly to **Beneflex, Inc, 1030 State St, Suite 2, Erie, PA 16501**, Fax: 814-461-6590
- Questions: 814-453-3107

Social Security # _____ Daytime Phone # _____

Employee's Name _____

Address: _____

E-Mail Address: _____

DESCRIPTION OF EXPENSES AND REIMBURSEMENT AMOUNT REQUEST

Medical Care Expenses for You & Your Family

Patient's Name	Relationship	Date of Service	Service Provider	Amount Requested

Sub-Total \$

Dependent Care (Daycare) Expenses

Dependent's Name	Dates of Service	Service Provider Please provider Soc. Sec. No.	Amount Requested

Sub-Total \$

TOTAL REQUEST FOR REIMBURSEMENT: \$ _____

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses listed on this form are eligible for reimbursement pursuant to the provisions of the GENERAL McLANE Flexible Spending Account, that they are not eligible for reimbursement by any other benefit plan, and that I will not include them as itemized deductions on my personal income tax returns. I understand and agree that I am solely responsible for determining the validity of the expenses for which I am requesting reimbursement.

Employee's Signature _____ Date _____

Retain one copy for your records