Medical Flexible Spending Account (and DCA)

Reimbursement Form

Instructions:

- ✓ Fill out each item on this form (including your signature at the bottom);
- ✓ Attach third-party documentation;
  - **FSA:** Itemized bills, eligible receipts, or explanation of benefits.
  - **Dependent Care:** Statement or receipt from the provider confirming the amount of dependent care expenses and the Tax I.D. number of the care provider.
- ✓ Email this form and all documentation to claims@beneflex-erie.com *(or fax the form to 814-461-6590 or mail it to us at: Beneflex-Erie, 3 Holland Street, Erie, PA 16507)*

Last 4 Digits of Social Security # _____ Day Time Phone # _____

First Name: _____ Last Name: _____

Address: _____

E-Mail Address: _____

Employer: _____

Medical Care Expenses for You and Your Family				
Patient's Name	**Relationship to Participant**	**Date(s) of Service**	**Service Provider**	**Amount Requested**
				$
				$
				$
				$
				$
			Sub-Total	$
Dependent Care (Daycare) Expenses				
Dependent's Name	**Date(s) of Service**	**Name of Service Provider**	**Tax I.D. (or SSN) of Service Provider**	**Amount Requested**
				$
				$
				$
			Sub-Total	$
			Total Request for Reimbursement	$

✓ I certify that the expenses on this form are eligible for reimbursement pursuant to my employer's FSA, 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 _____