

FlexWise™ REQUEST FOR REIMBURSEMENT

Employee Name _____ SS# _____

Name of Employer _____ email _____

INSTRUCTIONS:

1. *For expenses that are covered by your insurance, attach copies (photocopies acceptable) of the Explanation of Benefits (EOB) or the provider's bill to verify the amount paid by insurance. (You may not be reimbursed through the Cafeteria plan for expenses that are covered by your insurance.)*
2. *For all other reimbursable expenses, copies of all bills (photocopies acceptable) must be attached which show: Name & Address of the Provider; Reason for Charges; Date & Amount of the Charges. Canceled checks and credit card receipts are not an acceptable proof of expense. "Balance Forward" statements are not acceptable receipts. Prescription receipts must include the name of medication.*

A. MEDICAL EXPENSE REIMBURSEMENT

Date Incurred	Provider	Amount Claimed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total to be Reimbursed:		_____

B. DEPENDENT CARE EXPENSE REIMBURSEMENT (Provider's Tax ID # or Social Security # Required)

Services Provided	Day Care Provider	Amount Claimed
From _____ To _____	_____	_____
From _____ To _____	_____	_____
From _____ To _____	_____	_____
Total to be Reimbursed:		_____

C. READ THE FOLLOWING STATEMENT, SIGN AND DATE:

To the best of my knowledge and belief, the statements in this Request are complete and true. I am claiming reimbursement only for expenses incurred during the Plan Year. I certify that these expenses have not been, nor will be, reimbursed under any other benefit plan and will not be claimed as an income tax deduction. I authorize my flexible spending account(s) to be reduced by the amount requested.

Employee Signature _____ Date _____

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