



Request For Reimbursement

Employer: _____

Employee name (Please type or print): _____ Social Security #: _____

Employee address: _____
City State Zip

(Please check if this is a new address)

Dependent/Child Care LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Name of Dependent ^A	Age	Provider Name ^B	Provider ID #	Dates Service Provided ^C	Requested Amount of Reimbursement ^D	FLEX ONE Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

Provider's Certification/Verification

I certify that the above-described Dependent Care expenses were incurred by the employee named above.

Business/Provider Signature _____ Address _____

Unreimbursed Medical LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Patient Name ^A	Provider Name ^B	Description of Service ^C	Dates Service Provided ^D	Requested Amount of Reimbursement ^E	FLEX ONE Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Cancelled checks, credit card receipts or bills showing a previous balance or balance due only are not acceptable.

Provider's Certification/Verification

I certify that the above-described Unreimbursed Medical expenses were incurred by the employee named above.

Business/Provider Signature _____ Address _____

I request reimbursement from my FLEX ONE® Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Care Expenses that I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expenses for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Care Expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Date: _____ Employee Signature: _____

(See reverse for instructions.)

How to File a FLEX ONE® Request for Reimbursement

1. Complete the reverse side of this form, being sure to sign and date it. Failure to complete all areas can result in a delay in processing and claim reimbursement.
 2. Attach itemized bills, receipts or Explanation of Benefits (EOB's) which show:
 - name of person receiving service
 - nature of service or supplies furnished and charges for each item
 - date(s) of service
 - name of provider(s), address and tax identification number (Fed. ID # or Social Security #)
 3. The business/provider may sign this form in lieu of attaching a receipt.
 4. If you carry group insurance, first submit expenses to the insurance carrier. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible.
 5. Checks are not written for less than \$15.00.
 6. Requests for less than 15.00 will be applied to future requests.
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Qualifying Expenses

To qualify for reimbursement, expenses must be incurred during the Plan year for which you are requesting reimbursement.

1. Unreimbursed Medical Account – can be used for medical expenses for you or your family which are not covered by any other health plan. Items covered include, but are not limited to:
 - deductibles/coinsurance
 - medical, dental & vision services
 - hearing exams or aids
2. Dependent/Child Care Account – reimburses for care of your child or other tax dependent while you are at work. For services at a dependent care center, the center must comply with all state and local laws.

Specification for this account are:

- your child must be age 12 and under
 - your child or other dependent over the age of 13 must be incapable of self support and spend 8 hours or more a day in your home
 - the individual caring for your child age 12 and under or other dependent must not be a tax dependent
 - reimbursement cannot exceed \$5,000 annually (\$2,500 if married filing separate returns) or the earned income of you or your spouse, whichever is less
 - I understand that the taxpayer identification (Social Security) number of any dependent care service provider must be supplied to the IRS on my annual tax return.
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MAIL COMPLETED REQUEST FOR REIMBURSEMENT FORMS TO:

FLEX ONE®
Flexible Benefit Management
1932 Wynnton Road
Columbus, GA 31999-9950

800-323-5391