



PO Box 11088, Charlotte, NC 28220

Fax # 704-496-2367

**FLEXIBLE BENEFIT REIMBURSEMENT CLAIM FORM
(FSA/HRA/DCR/MRP)**

Company Name: _____

Employee Name: _____

SSN /Emp. ID#: _____

Request for Medical Expense Reimbursement

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
<i>* Please Attach Corresponding Receipts and/or Explanation of Benefits from Ins. Plan (Legible please)</i>			Total Claim \$	

Employee Certification

I request payment from the reimbursement account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I further certify that I have met all the requirements for eligible medical expenses. I understand that reimbursed expenses cannot be claimed as a deduction on my personal income tax return.

Employee Signature

Date

Eligible Medical Expenses:

In general, you may be reimbursed for an expense for "medical care" (as defined in Internal Revenue Code section 213(d)) that has not and will not be reimbursed by any other source and has not and will not be deducted on your income tax return. Examples of eligible expenses include co-insurance, deductibles, vision, dental, hearing, prescription and over-the-counter drug expenses not covered by your health plan. If there is any question on items eligible for reimbursement, consult with your employer's human resources department for clarification. **Revised 03/15/2007**