

Please Staple
Receipts Here



LIMITED USE FLEXIBLE SPENDING ACCOUNT

CLAIM FORM

REIMBURSEMENT REQUEST

\$50.00 minimum reimbursement for paper check. Any claims received under \$50.00 will be returned except for last check of the year. Does not apply to direct deposit.

Your Company's Name: _____
Your Name _____
Are you still employed at the above Company? Yes No If no, what date did you terminate employment?
Is this your first claim this year? Yes No Have you moved since your last claim or since you enrolled?
Email Address _____ If so, tell us where:
Day Time Phone _____ Street Address: _____
City: _____
State: _____ Zip _____

NON-REIMBURSED MEDICAL CARE: Complete only if you elected this on your initial enrollment form.

Provider Name	Service Rendered/Item Purchased	Service was for (Name/Relation)	Date of Service	Amount

*MUST BE DATE THE SERVICE WAS RECEIVED, NOT WHEN BILL PAID (If more lines required, use back of form)

NOTE: CLAIMS WITH INCOMPLETE OR MISSING INFORMATION OR MISSING RECEIPTS WILL BE RETURNED

READ CAREFULLY

I request reimbursement for my dependent care and/or non-reimbursed medical care as itemized above. Attached are receipts which provide: date of service, provider name, type of service, for whom the service was provided, and fee charged. These expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and that they cannot be claimed as credits or expenses on my personal income tax return.

I have retained copies of the receipts and documentation attached with this request. I understand that materials submitted will not be returned to me. Concepts In Benefits, Inc. does not retain materials after a request is processed.

YOUR SIGNATURE: _____ DATE: _____

Mail this form with receipts attached to:
Concepts in Benefits, Inc., 43 Constitution Drive, Bedford, NH 03110
Form and receipts may be faxed to: (603) 472-3281
Check your balance at www.mycbicard.com