Flexible Benefit Plan

Healthcare Reimbursement Claim Form

EMPLOYER NAME: _____

SECTION I: **Please type or print clearly**

Employee Name: _____ Social Security Number: _____

Address: _____ Group/Employee or ID Number: _____

City/State/Zip: _____ Employment Date: _____

Telephone Number: _____

SECTION II: **Authorization**

I certify that the expenses for which reimbursement is requested under my Flexible Benefit Plan were incurred by myself for my eligible dependents. I will not use expenses reimbursed through the Flexible Benefit Plan as deductions when filing my individual income tax return. I certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse or another member of my family.

_____ _____

Employee Signature Date

SECTION III: **List any health plans which you and/or your dependents are presently covered:**

	Plan Name	Coverage Type	Covered Individuals
☐ Your Health Plan		☐ Single ☐ Family	
☐ Your Spouse's Health Plan		☐ Single ☐ Family	
☐ Other Coverage		☐ Single ☐ Family	

SECTION IV: **Eligible Expense** – Expenses you have paid as your share of healthcare costs, expenses not covered by your plan, or other tax deductible healthcare expenses (verification attached)**:**

Description of Eligible Expenses	Expense For (name of dependent, relationship & Date of Birth)	Date of Service	Total Amount Billed	Amount Paid by any Plan	Your FSA Claim Amount

Return completed from to: Dunn & Associates

Mail: PO Box 2369 Columbus, IN 47202-2369 - Fax (812) 378-9967 - Email: info@dunnbenefit.com