FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT CLAIM FORM

Employer Name	Plan Number
Employee Name	Soc Sec #
Address	City, State, Zip Code

UNREIMBURSED MEDICAL/DENTAL/VISION

Patient Name	Dates of Service	Description	Reimbursement Amt. Requested
		Total Unreimbursed Medical/Dental/Vision	$

For Medical/Dental/Vision expense claims that were submitted to a medical plan or an insurance company but not paid by that carrier, attach copies of the Explanation of Benefits showing the patient portion.

For all other expenses, please attach the itemized bills.

DEPENDENT CARE

Dependents Name(s)	Dates of Care	Provider Signature and Tax ID/ Social Security Number	Reimbursement Amt. Requested
		Total Dependent Care	$

Employee Certification

I certify that all the above items requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program. I further certify that such items will not be deducted or taken as tax credits on my personal Income Tax Return(s).

______________________________ ____________________
Employee Signature Date

SUBMIT COMPLETED FORM TO:

CORE *Benefits, Inc.*
P.O. Box 80465
Fort Wayne, IN 46898-0465
Ph: 260.492.7451 866.744.8482 Fax: 260.492.7292