FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT CLAIM FORM

Employee Name:_____ Social Security #:_____

Employer Name: _____ Date:_____

Expense Description	Date of Service	Amount

CONTINUE LIST ON REVERSE SIDE IF NECESSARY

TOTAL:_____

Comments:_____

_____

Read Carefully: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the _____ with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan of coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature:_____

Address:_____

_____

INSTRUCTIONS:
This form is provided for you to file a claim for reimbursement of out-of-pocket expenses covered under your Flexible Spending Account.

1. Fill in your name (printed), social security number and today's date.
2. List the name of the person, company, or entity to which you paid the expense.
3. Enter the date and amount of the expenditure.
4. Total the expenses. A $5.00 service fee will be deducted for each claim submitted.
5. **Attach your Explanations of Benefit (and receipt, if applicable) to this form and mail to:**

FBC-125, Inc.
PO Box 5249
Gainesville, FL 32627

If you have any questions, please call 352-377-1239 (Gainesville).