2018
Flexible Benefits
Reimbursement Voucher

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Please read these instructions prior to completing the Reimbursement Voucher:	For Admin use only:
1. **Please complete all required information below. Attach additional vouchers if necessary.** 2. **Attach corresponding bills, receipts, necessary documentation that includes the provider of service, date of service, type of service, recipient of service and any insurance payments made on claim. In addition, for Dependent Care please indicate dates of service on reverse.** 3. **Read employee statement and sign and date the Reimbursement Voucher.** 4. **Mail to the address above, fax to 585.248.2488, or email to info@flexbene.com.** **Failure to submit a properly prepared Reimbursement Voucher AND documentation could result in a delay and/or denial in the process of your reimbursement.**	**Amt Approved:** $ _____ **Amt Denied:** $ _____ **Date: _____**

Part I: Employee Information

Employer:	Department:
Employee Name:	**Employee SSN:** **XXX-XX-___ ___ ___ ___**
Daytime Phone:	**Email Address:**	**May we contact you via email?** ☐ Yes ☐ No

Part II: Unreimbursed Medical, Dental, Vision Expenses

Date of Service	Type of Service Please check the appropriate box for each expense **MD**=medical **RX**=prescription **VS**=vision **DN**=dental **OT**=other	Recipient of Service	Service or Medicine Name	Diagnosis or Condition	Amount Requested
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
				Unreimbursed Medical Subtotal:	**$**

Part III: Child Care, Eligible Dependent Day Care Expenses
(Please Note: a current Dependent Care Registration Form must be on file for provider listed for reimbursement)

Dependent	Date of Birth	Provider	Date(s) of Service MM/DD/YYYY		Amount Claimed
			From:	To:	
			From:	To:	
			From:	To:	
		Dependent Care Subtotal:			**$**

Part IV: Disability/Other Health Insurance Premium
(Please Note: you must be enrolled for this benefit to apply for reimbursement)

Covered Person	Provider	Date(s) of Coverage MM/DD/YYYY (Please indicate dates on reverse)		Amount Claimed
		From:	To:	
		From:	To:	
	Premiums Subtotal:			**$**

Total Amount Requested:	**$**

To the best of my knowledge and belief, my statements in this Reimbursement Voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for the eligible plan participants. I certify that these expenses have not been previously reimbursed by this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.
I AUTHORIZE MY FLEXIBLE BENEFITS ACCOUNT TO BE REDUCED BY THE AMOUNT REQUESTED.

EMPLOYEE SIGNATURE: _____   **DATE:** _____

If you have any questions regarding this Reimbursement Voucher or your account, please contact us at:
800.836.8100 or info@flexbene.com