UNREIMBURSED MEDICAL CLAIM FORM

EMPLOYEE FLEXIBLE BENEFIT PLAN

COMPANY____

EMPLOYEE: ____

UNREIMBURSED MEDICAL EXPENSE ⟶ $______________________

Your reimbursement will be processed on the regular processing schedule for your employer.

Receipts must be attached to expense report and expenses must be incurred during the current plan year (or any Grace Period established by your employer) in order to receive reimbursement. If you do not know whether your FSA has a Grace Period, please contact your plan administrator.

Effective with the 2014 Plan Year, some employers elected to allow up to $500.00 in contributions to Unreimbursed Medical Expense FSA to be carried over to the following Plan Year. If you do not know whether your FSA has a Carry Over, please contact your plan administrator.

**I acknowledge that I have attached supporting documents such as receipts, vouchers, etc. to corroborate the expenses listed above.. I also understand that any unused salary reductions not subject to a Grace Period or a Carry Over will be forfeited at the end of the Plan Year. I understand that any expenses for which I am reimbursed under this Plan may not have been paid from a Health Savings Account (HSA), may not be claimed as income tax deductions, or have been reimbursed under any other benefit plan.

By signing below I certify that the expenses listed above have not been paid from a Health Savings Account (HSA) or been reimbursed, and are not reimbursable, under any other health plan coverage; and I certify that the expenses listed above have not been submitted to this Section 125 Plan previously, or to any other Plan in which I or my spouse are covered.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

______________________________ ______________

Signature Date

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