BENEFITS NETWORK, INC.

FLEXIBLE BENEFITS PLAN
REQUEST FOR REIMBURSEMENT

■ INSTRUCTIONS FOR SUBMITTING A CLAIM:

1. Complete Section A - Employee Information
2. Complete Section B - Claims and Expenses for Health Spending Account. **Attach receipts describing the services rendered, date of service (s) and amount paid, and for whom the services were rendered, such as all invoices, receipts, or other supporting documents.** (Such supporting documents become part of this claim and cannot be returned to you.) Explanation of Benefits Statements must be accompanied by a matching invoice/statement. Insurance coverage must be indicated if applicable.
3. Complete Section C – Attach receipts for each Dependent Day Care Spending Account claim indicating date of service, provider information (SS Number or Tax ID number), amount paid and for whom the services were rendered.
4. Photocopies of forms and documents are acceptable. **Note: The IRS has determined that cancelled checks (for medical expenses), balance forward, previous balance statements or charge card receipt statements are not acceptable documentation of expenses.**
5. All data obtained from the Client shall be held in confidence and shall **not** be made known to other persons, parties, or businesses without written permission from the Client.
6. **Fax or mail claim to:** **Flexible Benefits Administrator**
   Benefits Network, Inc.
   118 West Main Street, Suite 301
   Somerset, PA 15501
   Office (814) 445-4943 Direct (814) 289-4229 ***Fax (814) 445-3295*** ***Email: ttirko@benefitsnetwork.biz***

■ SECTION A – EMPLOYEE INFORMATION

Employer: _____

Employee Name: _____ Last 4 Digits SS#: _____
(First, Middle Initial, Last)

Address: _____**Is this a new address? YES / NO**

City, State, Zip: _____Phone _____

■ SECTION B – HEALTH CARE REIMBURSEMENT REQUEST

IF REIMBURSEMENT REQUEST INVOLVES EXPENSES FOR SPOUSE OR DEPENDENTS, PLEASE PROVIDE THE FOLLOWING:

RELATIONSHIP	NAME OF SPOUSE/DEPENDENT	BIRTHDATE

When indicating if claimant has medical, vision or dental insurance, please note this is any type of coverage provided to the claimant, not necessarily through your employer.

Please indicate if the claimant has:

Medical Coverage: □ YES □ NO
Dental Coverage: □ YES □ NO
Vision Coverage: □ YES □ NO

I certify that my eligible dependents or I have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source, nor do I expect them to be.

Health Care Total	Employees Signature	Date

■ SECTION C - DEPENDENT DAY CARE REIMBURSEMENT REQUEST

NAME OF DEPENDENT	BIRTHDATE	DATES OF SERVICE	NAME & ADDRESS OF PROVIDER	PROVIDER TAX ID # OR SS#
Day Care Total	Employees Signature			Date