*Flex*125™ Reimbursement Form

Date: _____
FAX - # Pages: _____

Please follow the steps below to thoroughly and accurately complete this form.

STEP 1: Company Name: _____ Day Phone: _____

STEP 2: Employee Name: _____ SSN: _____

STEP 3: Do you have the *my*SourceCard™ Debit Card? ☐ Yes ☐ No

STEP 4: FLEXIBLE SPENDING ACCOUNT CLAIMS

Date of Service (MM/DD/YY)	Name of Provider	Description of Service	Claim Amount
			$
			$
			$
			$
			$
			$
			$
			$
			$

STEP 5: CHILD/DEPENDENT CARE CLAIMS

Date of Service (MM/DD/YY)	Name of Provider	Provider Tax ID/SS#	Description of Service	Claim Amount
				$
				$
				$
				$
			Total:	$

Payout Schedule - Claim Reimbursement Checks are distributed twice a month.

If FBSC receives claims by 5 p.m. on the 5th/20th of the month, reimbursement checks/reports will be sent to the employer/employee by the 15th/30th.

STEP 6:

By signing this form, I acknowledge that my statements in this request for reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or other benefit plans and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account and/or Child/Dependent Care Account(s) to be reduced by the amount(s) requested.

Employee Signature: _____ Date: _____

Submit a Reimbursement Request in four easy steps...

1. Provide acceptable proof of paid expenses. We request that you send **COPIES** of your proof of expenses since they will not be returned to you. For tax purposes, you should retain the **original** proof of expense.

   Flexible Spending Account - A copy of the explanation of benefits sent to you by your carrier stating the portion of the claim paid **OR** a copy of the bill from the provider stating the services and date performed and method of payment used.

   Child/Dependent Care - Copies of the check referencing care provider's name, SS# and the dates of coverage **OR** a copy of receipt from the care facility, referencing their tax I.D. number (or SS#) and the dates of coverage.

2. Write the total amount for reimbursement on the front of this form.
3. Attach all copies pertaining to your claim to this form to (847) 440-9100.
4. Send request for reimbursement via mail or fax to: **Flexible Benefit Service Corporation**, *Defined Contribution Department*
   10275 W. Higgins Rd., Suite 500, Rosemont, IL 60018
   888-FLEX1ST (353-9178), Fax (847) 440-9100

*Flex*125 is a trademark of Flexible Benefit Service Corporation.

Revised 8/2005