

REQUEST FOR REIMBURSEMENT FROM EMPLOYEE FLEXIBLE SPENDING ACCOUNT

Please complete this form and attach appropriate receipts before submitting for reimbursement.

EMPLOYER: _____ DATE: _____
 NAME: _____ SS#: _____
 ADDRESS: _____ check if new address
 CITY: _____ STATE: _____ ZIP: _____
 E-MAIL: _____ PHONE: _____

PLAN YEAR: ***** Please fill out separate forms for separate Plan Years. *****

MEDICAL EXPENSE

SERVICE DATE	PROVIDER	DESCRIPTION	AMOUNT
TOTAL EXPENSE			<input type="checkbox"/>

COMMUTER EXPENSE

SERVICE DATE	PROVIDER	DESCRIPTION	AMOUNT
PARKING			
TOTAL EXPENSE			<input type="checkbox"/>

DAY CARE EXPENSE *Care performed by individuals can be substantiated with a canceled check if the provider's SSN is attached.*

SERVICE DATE	PROVIDER	Tax ID #	AMOUNT
TOTAL EXPENSE			<input type="checkbox"/>

To the best of my knowledge, the information provided in this request for reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an Income Tax deduction. I authorize my FSA amount to be reduced by the amount requested up to the total eligible for the Plan Year.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

For proper administration, this form and supporting documentation should be sent to:



ADMINISTRATIVE INFORMATION MANAGEMENT, INC.
 10353 Linn Station Rd
 Louisville KY 40223
 FAX: (502) 426-6569
 Email: Claim@aimadministrator.com

**** SAVE PAPER - USE THIS CLAIM FORM AS YOUR COVER PAGE. ****