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:			ZIP:
E-MAIL:			
PLAN YEAR:	* * * * * Please fil	l out separate forms for separate	e Plan Years. * * * * *
MEDICAL EXPENSE SERVICE DATE	PROVIDER	DESCRIPTION	AMOUNT
		TOTAL EXPENSE	
COMMUTER EXPENS SERVICE DATE PARKING	E PROVIDER	DESCRIPTIC	ON AMOUNT
TRANSPORTATION			
		TOTAL EXPENSE	
DAY CARE EXPENSE	Care performed by individuals can be su	ubstantiated with a canceled check if the	provider's SSN is attached.

DA SERVICE DATE **PROVIDER** AMOUNT Tay ID #

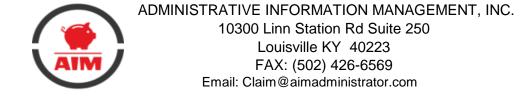
SERVICE DATE	TROVIDER		ANOUNT
TOTAL EXPENSE			

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:



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