



Medical FSA Reimbursement Request

When completed, FAX this form with correct documentation to: 502-695-9692

Employer Name: _____

Employee Name: _____

Social Security Number: _____ Employee Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ @ _____

If this is a new address, please indicate by checking this box.

Benefit Description:

Medical: \$ _____

Dental: \$ _____

Other: \$ _____

Transportation: _____ miles at 20 cents per mile \$ _____

- Explanation of Benefits (EOB)
Co-pay for office visit, emergency room, prescription, etc.
Expenses were not submitted to any insurance company. The expense is not the type covered by our insurance policy or the expense will not satisfy the deductible
Deduct from Previous Plan year funds.

TOTAL AMOUNT of Benefit Claim \$ _____

In order to prevent delays in processing, please make sure all areas are completed and supporting documentations are included. All supporting documents should 1) be copied on Letter size paper (8 1/2 X 11); 2) provide the date of service; 3) description of service; 4) provider's name; 5) the amount charged for the service and 6) the patient's name. Please be aware that cancelled checks will not substantiate an expense being incurred, only that a payment was made. Do not send original receipts

Your claim will be processed based on the date the claim is received. Please confirm with your financial institution concerning your direct deposit. Should you not receive your reimbursement, please contact our office immediately.

To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. Furthermore, I certify that these expenses have not been previously reimbursed on this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize FEBCO, Inc. to reduce my flexible spending account by the amount requested.

Employee Signature

Date

FEBCO
P.O. Box 5010
Frankfort, KY 40602 Fax: 502-695-9692