



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 mySourceCard™ Debit Card? Yes* No
 * If yes, please indicate below which claims have been paid using the card

STEP 4: FLEXIBLE SPENDING ACCOUNT CLAIMS

Date of Service (MM/DD/YY)	Name of Provider	Description of Service	Claim Amount	Debit Card
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>
_____	_____	_____	\$ _____	<input type="checkbox"/>

STEP 5: CHILD/DEPENDENT CARE CLAIMS

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

Payout Schedule - Claim reimbursements are distributed twice a month.

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

STEP 6:

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...

- 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 a 3rd party statement and/or receipt referencing the following information: date of service, type of service, dollar amount paid, dependent name and the provider's tax ID# or SSN.
- Write the total amount for reimbursement in the claim amount column.
- Attach all documentation pertaining to your claim to this form and fax to (847) 440-9100.
- Send request for reimbursement via mail, fax, or email

