



FLEXIBLE SPENDING ACCOUNT MEDICAL REIMBURSEMENT CLAIM FORM

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

SSN: _____

EXPENSES FOR: _____

Name

Relationship to Employee

HEALTH CARE EXPENSES

DESCRIPTION OF ELIGIBLE EXPENSE	DATE CLAIM INCURRED	TOTAL AMOUNT OF BILL	TOTAL PAID BY INSURANCE	REIMBURSEMENT AMOUNT DUE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTAL REIMBURSEMENT:				_____

I certify that the expenses for which reimbursement is requested under my employer's Medical Reimbursement Account are not reimbursable under any other medical plan. I will not use expenses reimbursed as deductions when filing my Federal Income Tax return. I authorize Self Funding Administrators to issue the amount requested above from my Medical Reimbursement Account in accordance with the terms and provisions of the Plan.

I understand that I am fully responsible for accurately identifying those expenses that qualify as eligible expenses and for any consequences should the Internal Revenue Service challenge the characterization of the payments made under the Plan.

I also understand that I am responsible for and liable to my employer for any reimbursement I may receive from my Medical Reimbursement Account in excess of my contributions to such account.

Signature

Date

INSTRUCTIONS FOR COMPLETING THE FLEXIBLE SPENDING ACCOUNT MEDICAL REIMBURSEMENT CLAIM FORM

Please read these instructions **carefully** before completing the claim form. Remember, if the claim form is filled out incorrectly, it will delay your reimbursement check.

1. Complete accurately all five columns of the claim form.
2. In order for the claim to be processed, copies of your receipts or itemized statements from your health care provider and/or an Explanation of Benefits (E.O.B.) from the health insurer must accompany this form. A copy of a cancelled check is NOT acceptable.
3. Make sure you sign and date the claim form before submitting it. Also check for any errors or omissions. Any claim forms that are not signed, dated or are incomplete will be returned to you for completion. This will cause a delay in your being reimbursed for expenses.
4. For your records you should make a copy of the claim form and attachments submitted.
5. Your completed form with attached receipts or itemized statements should be sent to:

**Self Funding Administrators
Post Office Box 6596
Annapolis, Maryland 21401**

If you have any questions, please contact your Human Resources Department or Self Funding Administrators.