PO BOX 17179 Irvine, CA 92623
Fax: (714) 437-1142 Attn: Flex Department

SECTION 125 FLEXIBLE SPENDING

REIMBURSEMENT REQUEST FORM

Employer Name	Branch Location	Group Number

Employee's Last Name	First	M.I.	Birthdate / /	☐ Male ☐ Female

Address	Street	Social Security Number

☐ CHECK HERE IF NEW

City	State	Zip	If Name Change, Give Former Name

I. Health Flexible Spending Account

Other Medical Expenses	Amounts
1. Deductibles / Coinsurance	$ ______________________
2. Unreimbursed Medical Expenses	$ ______________________
3. Unreimbursed Dental Expenses	$ ______________________
4. Unreimbursed Vision Expenses	$ ______________________
5. Other ____________________	$ ______________________
TOTAL AMOUNT REQUESTED	**$ ______________________**

EBA&M USE ONLY

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO VALIDATE ALL REIMBURSEMENT SUBMISSIONS. DOCUMENTATION MUST BE A COPY OF THE A RECEIPT WHICH INDICATES THE PERFORMANCE AND PAYMENT OF THIS SERVICE, OR A COPY OF AN EXPLANATION OF BENEFITS (EOB) FORM FROM HEALTH CARRIER. ACCOUNT BALANCE STATEMENTS CANNOT BE ACCEPTED. YOU MUST SUBMIT AN ITEMIZED RECEIPT OR EOB.

II. Dependent Care Flexible Account

Dependent Name(s)	Relationship	Age

DEPENDENT INFORMATION MUST BE COMPLETED FOR REIMBURSEMENT TO BE PROCESSED.

Daycare Provider Name ______________________

Address ______________________

City ______________ State ______________ Zip ______________

Tax I.D. or Social Security # ______________________

______________________ ______________________

Daycare Provider's Signature **Date**

Dates of Care	Amounts Paid
	$
	$
	$
	$

I hereby certify that the information in this voucher is correct and that I have not previously received reimbursement for these charges from this or any other plan of coverage. I understand that these expenses may not be claimed for credit or deduction on my personal income tax return.

Signature ______________________ Date ______________________