REQUEST FOR REIMBURSEMENT
USBA*flex* CLAIM FORM

860 East 9085 South
Sandy, Utah 84094
877-USBA125 * FAX 866-872-2125

Company Name:			
Employee Name:	Last First MI	**SS#**	
Employee Address:	Street City State ZIP	**PHONE**	( )

π **Please check if this is a new address**

Please read the back of this form Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
					Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I hearby authorize release of payment through my Flexible Spending Account(s). I hereby authorize your company or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____