



Request for Reimbursement

2012 10th Street Ste 8, Menominee MI 49858

Phone: (800) 871-9011 / (906) 863-3539

Fax Claims to: (866) 511-5503

Employer Name:	
Employee Name:	SSN:
Email Address:	
Address:	

Section 125 Flex Plan

- Medical Claim
- Dependent Care Claim
- Individual Insurance Claim

Qualified Transportation

- Parking
- Transit / Vanpooling

Health Reimbursement Account

- HRA Claim

Name Self / Spouse / Dependent	Date of Service From - To	Description	Dollar Amount
	-		\$
	-		\$
	-		\$
	-		\$
	-		\$
	-		\$
Total:			\$

To the best of my knowledge and belief, my statements in the requested expenses are complete and true. I am requesting reimbursements only for eligible expenses incurred during the applicable plan year for, myself and my eligible dependents. I certify that these expenses have not been reimbursed and that I shall not seek reimbursement under any other employer sponsored benefit plan and will not be claimed as an income tax deduction. Also, I certify that these expenses have not been previously reimbursed under this plan. I authorize that my plan account may be reduced by the amount of the requested reimbursement.

Note

Please provide proof of expense of any requested amount. The proof must include the date of service, service provided, the amount incurred, and who the services were provided to.

_____/_____/_____
Employee Signature Date