Flexible Spending Plan Reimbursement Voucher

*Please read the back of this form for instructions on how to complete this voucher *

YOUR EMPLOYER

YOUR NAME | S.S. NUMBER (Last 4 Digits)

YOUR ADDRESS (CHECKS WILL BE SENT TO THIS ADDRESS) CITY | STATE | ZIP

☐ PLEASE CHECK THIS BOX IF THERE IS A CHANGE OF ADDRESS.

Home Phone # ______________________ Work Phone # ______________________

Unreimbursed Medical Expenses

Receipts must include description of service, date of service, and amount.

Nature of Service	Date(s)	Amount
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
	TOTAL	$

Dependent/Child Care Expenses

*Submit receipt including date of service, amount, and SS# or Tax ID# **OR** have provider fill out and sign below**

Name of Day Care Provider	SS# or Tax ID#

Name of Dependent	Age	Disabled
		Yes ☐ No ☐

*Signature of Provider (if no receipt is attached)	Date

Description of Service	Date(s)	Amount
1		$
2		$
3		$
4		$
	TOTAL	$

Premium Expenses

(Privately held insurance policies)

Type of Insurance	Dates of Coverage	Amount
1		$
2		$
		$

☐ I authorize use of e-mail to communicate about this claim.

E-mail address: ______________________

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for re-crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

X ______________________

SIGNATURE | *Date*

Send completed vouchers to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(518) 641-0321 (800) 573-7474
Fax: (518) 641-0325
www.thepreferredgroup.com

BEE BUSINESS FORMS

Minimum Request:$25.00

†† SEE REVERSE FOR DETAILS