Flexible Spending Account

Employee Name	Unique ID Number	Employer

Please print or type. Completed form must be sent in with attached appropriate documentation.

Patient:		Relationship to Participant:	
Incurred Dates From - To	Provider	Proof of Expense Attach copy--See reverse side for explanation Check One	Dollar Amount
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		TOTAL	$

Patient:		Relationship to Participant:	
Incurred Dates From - To	Provider	Proof of Expense Attach copy--See reverse side for explanation Check One	Dollar Amount
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		TOTAL	$

Patient:		Relationship to Participant:	
Incurred Dates From - To	Provider	Proof of Expense Attach copy--See reverse side for explanation Check One	Dollar Amount
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		☐ Insurance Statement ☐ Bill/Receipt	$
		TOTAL	$

I certify that the amounts herein requested for reimbursement have been actually incurred as qualified expenses during a period while the undersigned was covered under the plan and have not, cannot and will not be reimbursed from any other benefit plan deducted on my income tax return, nor were they previously submitted for reimbursement under this Plan. I agree to provide supplemental information to process this claim as requested by the Plan Administrator. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim.

Signature ______________________________ **Date** ______________

Claims Department • 8220 Irving Road • Sterling Heights, MI 48312-4621
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ABS Automated Benefit Services