Medical Healthcare FSA Reimbursement Claim Form D

***** PLEASE PAY FROM FSA DOLLARS ONLY –**
EXPENSES ARE FOR DEPENDENTS NOT COVERED BY HRA***

Employee Name: _____ Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number:_____ Phone #:_____

Unreimbursed Medical Healthcare Expense Claims

Person for Whom Expense Incurred	Name of Service Provider	Date Incurred	Expense Description	Amount You Are Responsible For
Attach appropriate receipt(s) and submit with claim form.		**Total Medical Care Expense Claim**		

DIRECT DEPOSIT IS AVAILABLE (DOWNLOAD FORM FROM WWW.CPNFLEX.COM)

Read Carefully: When filing your claim, you must attach copies of the receipts. The receipt must include the service provider's name and the date and type of service for each expense. Canceled checks, credit card slips, or statements of balance due are not acceptable. If you fax your claim forms and receipts, please do not follow up with hardcopy. Always retain a copy of all forms and receipts. You may make copies of this form for your future use.

The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan and that the medical expenses have not been nor will be reimbursable under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature Date

CORPORATE PLANNING NETWORK, INC.
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