[COMPANY NAME]
FLEXIBLE SPENDING PLAN
CLAIM SUPPORTING STATEMENT

EMPLOYEE NAME:	**SSN**:
ADDRESS:	

Enclosed are copies of all supporting documents, receipts, vouchers, etc., to document the expenses listed below. The original receipts have been retained for my records.

Medical/Dental/Vision Reimbursements	$
Dependent Care Reimbursements (day care)	$

Any unused amounts in my account will be forfeited at the end of the plan year. I certify that I have not requested reimbursement under this plan or from any other source for these charges.

I CERTIFY that the above information is correct and complete.

Signature Date

KEEP TOP PORTION FOR YOUR RECORDS

[COMPANY NAME]
FLEXIBLE SPENDING PLAN
CLAIM SUPPORTING STATEMENT

EMPLOYEE NAME:	**SSN**:
ADDRESS:	

Enclosed are copies of all supporting documents, receipts, vouchers, etc., to document the expenses listed below. The original receipts have been retained for my records.

Medical/Dental/Vision Reimbursements	$
Dependent Care Reimbursements (day care)	$

Any unused amounts in my account will be forfeited at the end of the plan year. I certify that I have not requested reimbursement under this plan or from any other source for these charges.

I CERTIFY that the above information is correct and complete.

Signature Date

SEND BOTTOM PORTION FOR REIMBURSEMENT

BENEFIT ADMINISTRATORS
1250 Tower Lane
Erie, PA 16505

In Erie: (814) 454-0167
Nationwide: (800) 777-2524
Fax: (814) 459-2250