PULASKI COUNTY
FLEXIBLE BENEFIT PLAN – CLAIM FORM

Employee's Name_____SS#_____

HEALTH CARE EXPENSES_____I, the participant, hereby file claim for the medical expense(s) noted below and certify that each expense was incurred on the date and for the person and reason noted. The expense(s) listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my Benefits Card. **Attached are receipts or bills as evidence of my expenses incurred during the plan year**.
** Please note: A doctor's note must be attached if considered a "dual purpose" drug.
**** If you are a participant in the company's HSA you will ONLY be reimbursed for qualifying expenses related to Dental, Vision and Preventive Care.***

Date of Treatment	Person treated and Relationship	Type of eligible Expense	Amount of Expense
_____	_____	_____	$ _____
_____	_____	_____	$ _____
_____	_____	_____	$ _____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
		TOTAL	$_____

DEPENDENT CARE EXPENSES_I, the participant, hereby file claim for the child or dependent care expense(s) noted below and certify that each expense was incurred on the dates and for the persons noted. I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan. I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my Benefits Card. **Attached are receipts or bills as evidence of my expenses incurred during the plan year**. Please note that receipts must come from the day care provider and have the dates of service, a description of the expense, the amount charged and the provider's SS# or Tax ID#.

Care Provided By:	Date Care Provided	Person cared for and relationship	Amount of Expense
_____	_____	_____	$_____
NAME	_____	_____	$_____
_____	_____	_____	$_____
ADDRESS	_____	_____	$_____
_____	_____	_____	$_____
	_____	_____	$_____
_____	_____	_____	$_____
TAX ID # OR SS#	_____	_____	$_____
		TOTAL	$_____

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

_____ _____
EMPLOYEE'S SIGNATURE DATE

Mail This Claim Form To:	**Fax Claim Form To: (Please include cover sheet)**
Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155

Claims can also be scanned and emailed to FlexDivision@flex-admin.com

View your account on our website @ www.flex-admin.com or call FBA at (757) 340-4567.

PLEASE:
- **DO NOT mail your claim form if you fax it.**
- **KEEP a copy of all claim forms and receipts for your records**
- **NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address**

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