FAX OR MAIL TO:
FLEXIBLE BENEFITS ADMINISTRATOR
TR PAUL INC
PO BOX 5508
NEWTOWN, CT 06470
PHONE 1 (800) 678-8161 Ext 257 or Ext 214
FAX (203) 270-0927
NUMBER OF PAGES
FAXED________
FAX BY NOON EST

FLEXIBLE BENEFITS REQUEST FOR REIMBURSEMENT

EMPLOYEE NAME:	EMPLOYER:	
STREET ADDRESS:	SOCIAL SECURITY :	E MAIL ADDRESS:
CITY, STATE ,ZIP	IS THIS A NEW ADDRESS? ☐ YES ☐ NO	

INSTRUCTIONS : Please complete the information below for medical expenses incurred by you, your spouse or other eligible dependents.Photocopies of forms and documents are acceptable. Note: The IRS has determined that cancelled checks (for medical expenses), balance forward, previous balance statements or charge card receipts are not acceptable documentation of expenses. If the form is incomplete, it will be returned to you.

Please indicate if the claimant has:	Medical Insurance: ☐ YES ☐ NO	Dental Insurance: ☐ YES ☐ NO	Vision Insurance: ☐ Exam Only ☐ No Vision Coverage ☐ Exam & Glasses

A. HEALTH CARE REIMBURSEMENT REQUEST: (copays, deductibles, coinsurance amounts)

	EXAMPLE:	EXPENSE #1	EXPENSE #2	EXPENSE #3
NAME OF PATIENT/ RELATIONSHIP	***JOHN DOE, SON***			
DATE OF SERVICE	***1/1/04-1/30/04***			
TYPE OF SERVICE	***OFFICE VISIT, PRESCRIPTION***			
TOTAL EXPENSES				

B. OVER THE COUNTER EXPENSES:

NAME OF PATIENT/ RELATIONSHIP	EXAMPLE: ***JOHN DOE, SON***	EXPENSE #1	EXPENSE #2	EXPENSE #3
DATE OF SERVICE	***1/1/04***			
ITEM PURCHASED	***CONTACT LENS SOLUTION, BANDAIDS***			
TOTAL EXPENSES				

I certify that I, or my eligible dependents have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed or are not reimbursable through any insurance benefit plan. I will not seek reimbursement under any other health plan or flex plan. These expenses are for treatment of a medical condition and are not for general health or cosmetic purposes.

EMPLOYEE SIGNATURE ______________________________ DATE ________________

C. DEPENDENT DAY CARE REIMBURSEMENT REQUEST

NAME OF DEPENDENT	BIRTH DATE	DATES OF SERVICE	NAME & ADDRESS OF PROVIDER	TAX ID #
TOTAL EXPENSES				