Flexible Spending Accounts
Phone: 1-877-747-4141
Fax: 1-866-593-7125

Reimbursement Request - Claim Form

Personal Information: (Please Print)

Employer's Name	Date of Reimbursement Request
Employee's Name	Email Address
Employee's Social Security Number	Daytime Telephone Number

Health Care Reimbursement Request Expense(s)

Patient's Name	Relationship to Employee	Age	Date of Service	Type of Service (Medical, Dental, Vision)	Requested Reimbursement
1)					
2)					
3)					
4)					
5)					
6)					
				Total	$

Dependent Care Reimbursement Request Expense(s)

Dependent's Name	Relationship to Employee	Age	Date Range of Service	Requested Reimbursement
1)			to	
2)			to	
3)			to	
4)			to	
			Total	$

Dependent Care Provider Affidavit Information

Provider's Name:	Provider's Tax ID or SSN:

Dependent Care Provider, please read the following statement then sign and date.

I have provided adult/childcare services to the above listed individuals for the amouns and dates that are listed above:

Provider's Signature *Date*

Employee Certification for Reimbursement Request

I hearby certify that:

* The above information is correct
* I have not received, nor will I seek reimbursement for the expenses listed above from any other plan, including through the use of my Continuon Services Master Card®.
* The above listed expenses are not eligible for reimbursement under any other plan.

I also understand that:

- Reimbursement is not a guarantee that this payment is tax free;
- Healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return.

I allow Continuon Services or a represntative of Continuon Services to validate the supporting documentation(s) that I have provided with doctors, hospitals, medical care providers, pharmacists, employers, and other agencies or organizations (including other insurers) to prove these expenses are allowed under this plan and IRS guidelines.

Employee Signature *Date*

To expedite your reimbursement request, please complete all information completely and provide supporting documentation.

If you have questions, please contact us at: 1-877-747-4141.

Submit to: Continuon Services, LLC **or** **Fax to: 1-866-593-7125**
Attn: Flexible Spending Account Administration
P. O. Box 1379
Roswell, GA 30077-1379

SARF-10/10/2010