

**Form Provided by: Steve Elrod & Associates, Inc.
Request for Reimbursement
CLAIM FORM**

Employer:	
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Name:	Last	First	Mi	SS#
Address:	Street	City	State	Zip
				PHONE: ()

Please check if this is a new address
Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this Form

Copies of Receipts must be attached

* Information below must be completed

MEDICAL EXPENSE CLAIMS						
Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
Total						\$

DEPENDENT CARE CLAIMS							
Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax ID#/SS#	Claim Amount
							\$
							\$
							\$
							\$
Total							\$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

Employee Signature _____ Date: _____

**FOR FASTEST REIMBURSEMENT, FAX TOLL FREE TO 866-729-3539
LOCAL FAX 601-981-6605
OR MAIL TO :
VOLUNTARY BENEFITS ADMINISTRATORS, INC.
320-B EDGEWOOD TERRACE DR.
JACKSON, MS 39206
VOICE TOLL FREE: 866-730-3539
WEB PAGE: <http://www.vbaonline.com>**