14110 Airport Road, Suite 100, Gulfport, MS 39503
Telephone: (228) 865-0514 or (800) 847-6621
Fax: (228) 865-0550 or (800) 796-8834

FLEXIBLE SPENDING ACCOUNT HEALTH CARE REIMBURSEMENT REQUEST

Name: ______________________________
SSN #: ______________________________
Employer: ______________________________

Instructions: Complete the information below for Health Care Expenses incurred by you, your Spouse, or other eligible Dependents. (For information as to what Health Care Expenses can and cannot be reimbursed, see the Summary Plan Description.) You must provide insurance EOBs, hospital or doctor bills, pharmacy receipts or other evidence from independent third parties that the Expenses were incurred. Receipts should include date of service and description of service. **Canceled checks or cash register receipts will not be accepted.** Be sure to provide all information requested on this Form. If the Form is incomplete, it will be returned to you. Please date and sign the Form, then send it along with your supporting documents to: Select Administrative Services, Attn: Flexible Spending Account, 14110 Airport Road, Suite 100, Gulfport, MS,39503

Date Expense Incurred							
Name of Person Receiving Medical Service and Relationship to you							
	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Type of Service							
Reimbursement Requested							

Total Reimbursement Requested ______________

Read Carefully

To the best of my knowledge and belief, my statements on this Form are complete and true. I certify all of the following: either I, my spouse or my dependent has received the services described above on the dates indicated, and the expenses qualify as valid Medical Care Expenses under Code (213(d), as further defined in the Health FSA Document (the "Plan"). These expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other plan, and I will not seek reimbursement for them under the major medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. I understand that I may be asked to provide further detail about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me). I authorize the above expenses to be reimbursed from my Health FSA Account..

____
Employee Signature

____
Mailing Address

____
Date