

# REIMBURSEMENT REQUEST FORM

For Flexible Spending and/or Dependent Care Accounts

Mail or Fax with attached receipts to:

ADVANCED BENEFIT STRATEGIES  
 15 New Britain Avenue  
 Unionville, CT 06085  
 Attn: Section 125 Administration  
 Fax (860) 673-2207  
 Tel (877) 732-8125

New Address? \_\_\_\_\_

Employer	Employee Name		
Home Mailing Address	Social Security Number		
	City	State	Zip Code
Phone Number where you can be reached during the day			

Name Change? \_\_\_\_\_ Former Name \_\_\_\_\_

I certify that the following reimbursement submissions are for expenses incurred for my spouse my eligible dependents or myself. I will not claim credit for these expenses on my individual income tax returns and I will not receive payment from any other source for any of these expenses.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Documentation must be attached to verify all submissions and must include the dates of services. Cancelled checks are not a sufficient form of receipt.** Acceptable forms of documentation are:

- Co-payment receipts for office visits
- Copy of Explanation of Benefits from your insurance showing that the charges were not covered
- Pharmacy register receipt for prescription co-pays
- Receipt from a dependent care provider

HEALTHCARE REIMBURSEMENT SUBMISSIONS - use second form if necessary		
Date of Expense	Type (Rx, co-pay, contact solution etc.)	Cost
		\$
		\$
		\$
		\$
		\$
		\$
		\$
TOTAL:		\$

DEPENDENT CARE REIMBURSEMENT SUBMISSIONS				
Date of Services	Dependent(s) Name(s)	Age of Dependent	Name & Address of Provider	Cost
				\$
				\$
				\$
TOTAL:				\$