

**FLEXIBLE SPENDING ACCOUNT •• Group Name \_\_\_\_\_**  
**REIMBURSEMENT CLAIM FORM**

Employee Name (please print): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date: \_\_\_\_\_

Expense Description	Date of Service	Amount

**TOTAL:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Read Carefully:** The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under their employer's Flexible Benefits Plan. The undersigned also certifies that such expenses have not been reimbursed or are not reimbursable under any other health plan of coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim that is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan that relate to such expense.

**Employee Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**INSTRUCTIONS:**  
This form is provided for you to file a claim for reimbursement of out-of-pocket expenses covered under your Flexible Spending Account.

1. Fill in your name (printed), social security number and today's date.
2. List the name of the person, company, or entity to which you paid the expense.
3. Enter the date and amount of the expenditure.
4. Total the expenses. A \$3.00 transaction fee will also be deducted from your account.
5. **Attach your Explanations of Benefit (and receipt, if applicable) to this form and mail to:**

FBC-125, Inc.  
1239 N. W. 10th Avenue  
Gainesville, FL 32601

If you have any questions, please call (352) 377-1239 (Gainesville).