



Flexible Spending Account Claim Form

BeniComp Inc.
 8310 Clinton Park Dr.,
 Ft. Wayne, IN 46825
 (260) 482-7400 ■ 1-800-837-7400
 Fax: (260) 482-8991

Your Name			Your Social Security Number	
Last	First	Middle Initial	<input type="text"/>	<input type="text"/>
Address			Phone #:	
City	State	Zip	Employer Name	

Un-reimbursed Medical / Dental / Vision				
Patient Name	Date of Service	*Reason For Reimbursement	Provider Name	Requested Amount of Reimbursement
Total Un-reimbursed Medical/Dental/Vision				

*When filing for expenses eligible under your insurance, but not paid (Deductibles, Co-Insurance, Etc.), attach copies of the Explanation of Benefits from your insurance company, showing the patient portion or denial of claims.

For other expenses, attach a receipt or itemized bill that includes the information requested above.

Dependent Care				
Name of Dependent Receiving Care	Age	Dates Care Provided	Provider Name / Tax I.D.	Requested Amount of Reimbursement
Total Dependent Care				

 Provider Signature

 Date

I certify that these are legitimate expenses, which my dependents or I have incurred. I understand expenses must qualify as a deductible expense for federal income tax purposes and cannot be reimbursed by any other source or used as a deductible on my personal income tax return (s).

 Signature

 Date