Flexible Spending Account Claim Form

BeniComp Inc.
8310 Clinton Park Dr.,
Ft. Wayne. IN 46825

(260) 482-7400 ■ 1-800-837-7400

Your Name Last First Middle Initial	Your Social Security Number
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 expensive 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	Requested Amount of Reimbursement
			Total Dependent Care	

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 _____