Request for FSA Reimbursement

_____(Company Name)

NAME:	Last First MI	☐	Please check if this is a new address
ADDRESS:	Street City State ZIP	**PHONE :**	( )

HEALTH CARE EXPENSE CLAIMS					
Date of Service	**Patient Name**	**Relationship**	**Description of Service**	*** OTC? * Y / N**	**Claim Amount**
				Total:	$

***OTC**: You must submit a valid written Prescription for Over-the-Counter Expenses. OTC Expenses submitted without the Prescription will be denied.

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, or files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____ **Date:** _____ /_____ /_____

PLEASE EMAIL, MAIL OR FAX THIS FORM AND YOUR RECEIPT(S) TO:

AVERILL ANDERSON, LLC

316 SOUTH MAIN STREET, WEST BEND, WI 53095-3342

FAX: 1-800-861-8741 PH: 1-800-388-0964

EMAIL: FSA@AVERILLANDERSON.COM