



FLEXIBLE REIMBURSEMENT FORM

Company Name: _____

Your Name: _____ Social Security Number: _____

Phone Number: _____

Mailing Address: _____

New Address: Yes No

Please indicate the amount of your expense(s) below. Your insurance premiums, if applicable, are paid automatically and do not need to be listed below.

Child & Dependent Care: \$ _____ *

Medical, Dental, Etc. (not paid by insurance) \$ _____ *

* Always attach a proof of expense (receipt, paid billing statement or "explanation of benefits" from your insurance company). All proofs of expenses MUST include the date of service.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses. I certify that these expenses have not been and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction and that these expenses have been incurred during the Plan year for which I am seeking reimbursement.

I authorize reduction of my Flexible Benefits Account by the amount of the claim.

Employee Signature: _____

Mail, Fax, or E-mail this form with proof(s) of expenses to:
AmeriBen/IEC Group - P.O. Box 7186 - Boise, Idaho 83707 - Fax: (208) 424-0595
Toll-Free Fax: (800) 723-4703 - E-mail: flex@ameriben.com

**If you have any questions for completing this form, please feel free to call our
Customer Care Department: (800) 786-7930**