

Do not use this form for services paid with an FSA debit card. Proof of expenses must be attached. Bills, statements, or *Explanation of Benefits (EOB)* from medical plans are required proof of expenses. IMPORTANT! Cancelled checks and credit card receipts are **not** sufficient proof of expenses.

SECTION I. EMPLOYEE INFORMATION. Please print legibly.

Full Name as it appears on your FSA debit card				Social Security No.
Street Address	City	State	Zip	Phone No.

HEALTH CARE EXPENSES

Please only report one expense per block. Combining multiple expenses in one block may delay reimbursement.
If expense was incurred for eligible dependent, indicate type of relationship. Use "C" for child, "S" for spouse or "O" for other.

Date of Service	MM	DD	YYYY	Type of Service	<input type="checkbox"/> Dental <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Prescription	Amount \$
Name of Provider/Merchant:						
Dependent Name	Relationship to Employee			Birthdate	MM/DD/YYYY	

Date of Service	MM	DD	YYYY	Type of Service	<input type="checkbox"/> Dental <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Prescription	Amount \$
Name of Provider/Merchant:						
Dependent Name	Relationship to Employee			Birthdate	MM/DD/YYYY	

Date of Service	MM	DD	YYYY	Type of Service	<input type="checkbox"/> Dental <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Prescription	Amount \$
Name of Provider/Merchant:						
Dependent Name	Relationship to Employee			Birthdate	MM/DD/YYYY	

DEPENDENT CARE EXPENSES (Daycare)

Please only report one expense per block. Combining multiple expenses in one block may delay reimbursement.

Date of Service	MM	DD	YYYY	Dependent Care Provider:	Amount \$
Dep. Care Provider Taxpayer ID or SSN	Dependent Name		Relationship to Employee	Birthdate	MM/DD/YYYY

Date of Service	MM	DD	YYYY	Dependent Care Provider:	Amount \$
Dep. Care Provider Taxpayer ID or SSN	Dependent Name		Relationship to Employee	Birthdate	MM/DD/YYYY

Date of Service	MM	DD	YYYY	Dependent Care Provider:	Amount \$
Dep. Care Provider Taxpayer ID or SSN	Dependent Name		Relationship to Employee	Birthdate	MM/DD/YYYY

☐ Check box if signed by Dependent Care Provider. Dependent Care Provider Signature: _____ Date: _____
Necessary only if receipt is **not** provided.

SECTION II. CERTIFICATION AND AUTHORIZED SIGNATURE

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I further certify that if the above expenses are not eligible, I will remit payment in the amount of the ineligible expense to the plan. Additionally, these expenses are not being claimed as tax deductions under the IRS code.

Employee Signature	Date Signed
x	

MAIL or FAX: QualChoice ■ ATTN: FSA Dept ■ PO Box 25610 ■ Little Rock, AR 72221 ■ F: 501.707.6845 ■ P: 501.219.5133 or 866.724.3570