FLEXIBLE BENEFITS PLAN

BENEFIT REQUEST FORM

For Plan Year Ending _____

Print Full Name: _____ Social Security Number: _____-_____-_____

I seek reimbursement as provided under the Flexible Benefits Plan for the following expenses I've incurred during the above Plan Year. I've attached a written statement or receipt from an independent third party for all such expenses (other than group-term life and outside health insurance premiums).

A. DEPENDENT CARE EXPENSES (Daycare, pre-school, adult daycare)

	Provider	Date Incurred	Invoice Attached (✓)	Cost Incurred
1.	_____	_____	❒	_____
2.	_____	_____	❒	_____
3.	_____	_____	❒	_____
4.	_____	_____	❒	_____
5.	_____	_____	❒	_____
6.	_____	_____	❒	_____
7.	_____	_____	❒	_____

Total Dependent Care Claim $_____

C. HEALTH EXPENSES (Examples: Non-insurance-covered medical, dental, drugs, optical, deductibles, co-pays, etc.)

	Provider	Date Incurred	Invoice Attached (✓)	Cost Incurred
1.	_____	_____	❒	_____
2.	_____	_____	❒	_____
3.	_____	_____	❒	_____
4.	_____	_____	❒	_____
5.	_____	_____	❒	_____
6.	_____	_____	❒	_____
7.	_____	_____	❒	_____

Total Health Claim $_____

B1. GROUP-TERM LIFE INSURANCE PREMIUMS INCURRED TO DATE $_____

B2. OUTSIDE HEALTH INSURANCE PREMIUMS INCURRED TO DATE (Cannot include any payroll-deduction insurance of your spouse)

Health Insurance: $_____ Dental Insurance: $_____ Disability Insurance: $_____

Contact Lens Insurance: $_____ Optical Insurance: $_____ Other Insurance: $_____

Total Outside Health Insurance Premium Claim $_____

I have not been paid by insurance or under this Plan or otherwise for any of the expenses reported in this Form and no claim has been made or will be made for such reimbursement. A copy of this completed Form shall serve as an original for all purposes. I understand that if I've forfeited any pay because the expenses I submitted were less than my election, I generally have six months after the Plan Year end to submit additional claims. In the event there is any misstatement or miscomputation in this or any attached forms, or if the Employer makes an over reimbursement, I understand that I'll be liable for all taxes, penalty, and interest that may be imposed upon either the Employer or myself by the IRS or any state and local government agency with respect to any Benefits received by me. I represent that the total expenses claimed on this Form, in any category, together with prior reimbursements I've already received in such category, do not exceed my elections for the category.

I declare that the information I have furnished above is, to the best of my knowledge and belief, true, correct and complete.

X_____ _____

Participant's Signature Date

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