Compassion Health Care
Flexible Spending Account - Request for Reimbursement

Employee Name: _____

Instructions to receive reimbursement:
(1.) Complete this form entirely, listing each service separately
(2.) Attach the required documentation
(3.) Read and sign the authorization statement on the back
(4.) Submit to Human Resources.

Dependent/Child Care:

Name of Dependent	Provider Name	Provider Tax ID Number	Dates Service Provided	Reimbursement Amount Requested

Documentation Required for Reimbursement:
Please attach a receipt or itemized bill from the provider listing the information required above. Canceled checks or bills showing only a payment or previous balance are not acceptable.

Unreimbursed Medical:

Patient Name	Provider Name	Dates Service Provided	Description of Service	Reimbursement Amount Requested

Documentation Required for Reimbursement:
Please attach a third-party receipt or itemized bill listing the information required above. If you are requesting reimbursement for medical services that are covered by insurance a copy of the EOB (Explanation of Benefits) is also required. Canceled checks, credit card receipts or bills showing only a payment, balance due or previous balance are not acceptable.

Authorization:

I request reimbursement from my Flexible Spending Account as listed on page one and certify that these are eligible expenses that I or my dependents incurred. I understand that medical expenses must qualify as deductible expenses for federal income tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that dependent care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) number(s) of any dependent care service provider(s) will be supplied to the IRS. I hereby authorize Compassion Health Care, the Plan, AFLAC and FLEX ONE, their respective agents, subcontractors or employees to use the information provided above to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose any and all such information as is reasonably required for such purposes. I further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of administering the Plan (including the processing or evaluating of my claim for benefits under the Plan) or detecting or preventing fraud. This authorization does not and is not intended in any way limit any right Compassion Health Care, the Plan, AFLAC and FLEX ONE, their respective agents, subcontractors or employees may have under any applicable state or federal law or regulation regarding the use of such information.

Employee Signature: _____ Date: _____