REIMBURSEMENT REQUEST: Flexible Spending Accounts

Employee Information

Employer Name THE UNIVERSITY CORPORATION

Employee Name _____ SSN _____

Phone Number _____

Claim Information

Date of Service	Name of Service Provider	Expense Description	Requested Amount
			$
			$
			$
			$
			$
			$

Total Amount Requested: $_____*

* Please attach to this form all itemized bills, receipts, or any explanation of benefits.

- Read Carefully Before Signing Below -

I certify that all expenses for which reimbursement of payment is claimed by submission of this form:

- were incurred during a period while I was covered by the flexible spending plan with respect to such expense,
- have not been or are not reimbursable under any other health plan coverage,
- are proper under the plan, and
- that I am fully responsible for the sufficiency and accuracy of all information related to this claim,

or I may be liable for payment of all related taxes on the amounts paid from the plan relating to such expense.

_____ _____

Employee Signature Date

Submit Claims to Flex Advantage:

Fax to: (877)561-1661 or,

Mail to: 43471 Ridge Park Drive, Suite B, Temecula, Ca 92590

For assistance with all flexible spending claims call toll free (877) 506-1660