

Hewitt Coleman
 PO Box 6708
 Greenville, South Carolina 29606
 (864) 240-5844 fax: (864) 255-4864

FLEXIBLE BENEFITS PROGRAM CLAIM FORM

GROUP:	GROUP#:
EMPLOYEE NAME:	SOCIAL SECURITY #:

Please indicate below the amount of expenses you are claiming. Attach itemized receipts and retain copies for your files. If you have other medical, vision and/or dental coverage you must send a copy of an explanation of benefits (EOB) from your medical, vision and/or dental carrier to receive reimbursement.

If you do not have any other medical, vision and/or dental coverage for yourself and/or dependent(s) you must indicate by checking here. ()

MEDICAL REIMBURSEMENT

DATE OF SERVICE	PATIENT	DESCRIPTION	AMOUNT
CLAIM TOTAL			\$

(Please be sure to specify under the description what the service or supply is that you are submitting for reimbursement.)

Is this for an herbal supplement? Yes _____ NO _____

I understand that the use of this service or supply is strictly to be used by my family or myself. I certify that this information is correct, complete and meets all requirements for eligible healthcare expenses.

Employee's Signature: _____ **Date:** _____

DEPENDENT CARE REIMBURSEMENT

DEPENDENT DAY CARE: _____
 DATES OF SERVICE: _____
 DAYCARE PROVIDER NAME: _____

I also certify that the total Dependent Day Care expenses (if any) for which I am requesting reimbursement do not exceed the lesser of my or my spouse's earned income for the plan year. I understand that reimbursed expenses cannot be claimed on my personal income tax return. Also, any unused funds in my account at the end of the plan year will be forfeited. I certify that this information is correct, complete and meets all requirements for eligible dependent care expenses.

 Employee's Signature Date
If you have any questions or concerns please fill free to call the number listed above.