

**Hewitt, Coleman & Associates**  
**PO Box 6708**  
**Greenville, South Carolina 29606**  
**(864) 255-4865 fax: (864) 255-4864**

**FLEXIBLE BENEFITS PROGRAM CLAIM FORM**

**GROUP:** \_\_\_\_\_ **GROUP#:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

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 OF EXPENSE							
AMOUNT							
							<b>TOTAL</b>

**OVER THE COUNTER MEDICATIONS**

**This section MUST be completely filled out in order to receive reimbursement.**

**Is this for an herbal supplement? Yes** \_\_\_\_\_ **NO** \_\_\_\_\_

DATE OF SERVICE							
PATIENT							
DESCRIPTION OF EXPENSE							
AMOUNT							
							<b>TOTAL</b>

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

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 \_\_\_\_\_

TAX ID# \_\_\_\_\_

**DAYCARE PROVIDER SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

*(DayCare Provider must complete if you do not have a paid receipt)*

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.*