Benergy OS OUTSOURCING STRATEGIES

TOTAL ACCESS FSA
HEALTH CARE FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Your Employer Name: _____

Employee Name: _____
(Please print or type)

Social Security Number: _____ – _____ – _____

Date of Service	Service Provider	Individual Receiving Service	Amount Requested
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		Total:	**$**

Supporting Information: For health care expenses you must submit a written **statement from the provider** of services, which describes the services, the dates of services and the charges. If the expense includes deductibles, co-payments or other items not paid by your health insurance plan(s) submit a copy of the **Explanation of Benefits** sent to you by your insurance company.

PLEASE SIGN THE FOLLOWING STATEMENT:
I certify that I (or my dependents) have incurred the expenses for which reimbursement is claimed. I declare that these expenses have not been reimbursed previously under this plan and have not been, and will not be, reimbursed under any other insurance plan or other program. I understand that these expenses cannot also be claimed as a Federal Income tax deduction or credit on my Federal Income Tax Forms.

Employee Signature:_____**Date**:_____

Instructions:
Mail, fax or email this form and supporting documents to:
Benergy OS
Attn: FSA
353 S. Potomac Street
Waynesboro, PA 17268
(fax): 516-414-5122
FSA@benergyos.com
If you have any questions contact Benergy OS at FSA@benergyos.com or 800-768-4909