



Instructions

1. Complete all sections, giving all requested information.
2. Sign and date the form.
3. Attach a copy of an itemized bill or receipt and send to Colonial HealthCare by mail or fax.

Note: If you are submitting expenses eligible under another insurance plan, you must submit an Explanation of Benefits (EOB) statement.

Mail to:

Colonial HealthCare, Inc.
FSA
P.O. Box 827, Lanham, MD 20703-0827

Or Fax to: 301-306-2509

For inquiries, please call: (877) 819-9413

Employee Information

NAME (Last)	(First)	(MI.)	SOCIAL SECURITY NUMBER
			- -
HOME ADDRESS- Please check here if the following is a new address: <input type="checkbox"/> (Street)			EMPLOYER
(City)	(State)	(Zip Code)	DAYTIME PHONE NUMBER
			- -

Dependent Care Account Request for Reimbursement Flex Convenience Card Receipt(s)

	DEPENDENT CARE PROVIDER'S NAME	TAXPAYER I.D. NUMBER	DATES EXPENSES INCURRED		PATIENT'S NAME	RELATION TO EMPLOYEE	AGE	REIMBURSABLE EXPENSE AMOUNT
			FROM	TO				

IMPORTANT – The provider must certify only if you are not submitting a receipt.

TOTAL »

I (provider) certify that the above changes have been incurred during the time period specified.

Signature of Provider

Date

Health Care Account Request for Reimbursement Flex Convenience Card Receipt(s)

	EXPENSES PAID TO (PROVIDER'S NAME)	DATES EXPENSES INCURRED		PATIENT'S NAME	RELATION TO EMPLOYEE	REIMBURSABLE EXPENSE AMOUNT
		FROM	TO			

TOTAL »

Employee Certification

I request reimbursement from my Flexible Spending Account(s) for the expenses itemized above. I have attached a statement from the provider of services showing the amount of each expense and the date it was incurred. I certify that these expenses qualify for reimbursement under the Internal Revenue Code and that the expenses are not reimbursable from any other source. I also understand that reimbursement expenses cannot be claimed as deductions on my personal tax return.

The information on this Request for Reimbursement is true and correct to the best of my knowledge.

Employee Signature

Date