

MEDICAL EXPENSE REIMBURSEMENT FORM

| Employee Information | |
|----------------------|------------------------|
| Name | Social Security Number |
| Company Name | |

The attached documentation is for purchases made with my Benny Benefits Card.

| Date of Service | Person Incurring Expense | Relationship | Provider | Description of Service | Amount Requested |
|---|--------------------------|--------------|----------|------------------------|------------------|
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| Total Amount of Reimbursement Requested | | | | | |

I request reimbursement for the attached expenses under my employer's flexible benefits plan. I certify that I, or my eligible dependents, have incurred these expenses. If the expenses are covered under health or dental insurance, attached is an Explanation of Benefits (EOB) which shows that the insurance company did not pay for this expense because of deductibles, co-payments or non-allowed charges. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code and will not be claimed as a deduction on my personal income tax return.

Employee Signature _____
Date

Change of address? No Yes New Address: _____

CDSA
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