Flexible Spending Accounts
Section 125

REIMBURSEMENT REQUEST FORM

WE HAVE A BETTER PLAN.

P.O. Box 458022 • Westlake, Ohio 44145
Toll Free: 800.634.0173 • **Fax:** 440.250.4301
benefits@jpfarley.com • **www.JPFarley.com**

Employer	Branch Location		Group Number	
Employee's Last Name	First	M.I.	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Home Address	Street	☐ Check here if new	Social Security Number (000-00-0000)	
City	State	Zip	If Name Change, Give Former Name	
Home Phone ( ) -	Work Phone ( ) -		Email Address	

ATTACH RECEIPTS & DOCUMENTATION

☐ HEALTH CARE REIMBURSEMENT CLAIM(S) $ ______________

Documentation includes a copy of the billing, a receipt which indicates the performance and payment of this service, a copy of an explanation of benefits form from your medical carrier or doctor's prescription as applicable to your particular reimbursement request.

- Provider Name
- Address
- Patient Name
- Actual Date(s) of Service
- Description of Service
- Proof of Liability/Service

☐ DEPENDENT CARE REIMBURSEMENT CLAIM(S) $ ______________

Supporting documentation must include the following information.

- Provider Name
- Address
- Dependent(s) Name
- Dependent(s) Date of Birth
- Date(s) of Service
- Tax ID (company) / SSN (if individual)

☐ OTHER QUALIFIED FLEX REIMBURSEMENT CLAIM(S) $ ______________

Include **Transportation/Parking Reimbursement Claims**.
Supporting documentation for **Individual Insurance Premium Claims** must include an itemized statement.

▶ Note:
Proper supporting documentation must be attached to validate all submissions for reimbursement. Attach additional documentation as needed for each claim.

▶ Acknowledgement:
I validate that the requested reimbursements are accurate and all services have been completed. Further, I validate that I have not been or cannot be compensated for these from any other source.

Signature of Plan Participant ______________________ Date ______________