



Reimbursement Form

Name:

Last	First	Last Four Digits of SSN#
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Address:

Street	City	Zip
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Employer:

Email:

Phone#: ()

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Health Care Reimbursement Worksheet

DOS Start Date	DOS End Date	Recipient	Provider/ Merchant Name	Dollar Amount
TOTAL				\$

Day Care Reimbursement Worksheet

Day Care Start Date	Day Care End Date	Name of Child	Name of Provider	Dollar Amount
Provider Tax ID or SSN#:			TOTAL	\$

Preferred method of reimbursement (circle one) CHECK DIRECT DEPOSIT

Please include bank information for direct deposit:

account #

routing #

I request reimbursement from my account. I certify that the information provided is true and correct, that these expenses are not and will not be covered by any insurance program or other reimbursement program, and that I have not nor will not claim these expenses as income tax deductions on my income tax return, and that the expenses submitted qualify as required. I also understand that the Internal Revenue Service (IRS) may require proof that these are eligible expenses, and that I am responsible for providing such proof.

SIGNATURE: _____

DATE: / /

NEW ADDRESS & FAX NUMBER

Please send this form along with your documentation to: **FlexSave of America, Inc. • 22811 Greater Mack • Suite 201 • St. Clair Shores • MI. • 48080 or fax to (866) 205-0585**

