

Flexible Spending Account  
 FAX Reimbursement Claim Form to  
**951-656-9276**



**For Flex Spending Reimbursements**

You can fax your claims for reimbursements (or mail to address below)

- Complete the Claim form below **MAKE SURE TO SIGN IT TOO**
- Fax the form along with copies of your documentation
- You'll receive reimbursements with your next cycle
- If form isn't properly filled out and signed, your claim will be returned unpaid

Do not mail claims that you fax. Do not send BennyCard Receipts with this form. Please use this number only for claims.

**Reimbursement Claim/Request Form**

\_\_\_\_\_  
 Name of Employer  
*Nombre de Empleador*

\_\_\_\_\_  
 Name of Employee  
*Nombre del Empleado*

\_\_\_\_\_  
 Social Security Number  
*Numero De Seguro Social*

I certify that each item claimed for reimbursement matches the enclosed documentation, and that none of the expenses have been previously reimbursed—nor are they reimbursable—under this or any other benefit plan and will not be claimed as an income tax deduction. Further, the amounts requested for reimbursement are documented by the copies of the attached bills, invoices and/or receipts, etc.

*Las sumas sometidas estan documentados, en los recibos y fracturas incluidas. Afirmo que cada articulo reclamado en la forma de solicitud igualan los documentos incluidos y ninguno de estos gastos ha sido previamente reembolsado bajo este u otro Plan y no sera declarado como deduccion en mi ingreso taxable.*

Indicate the amount, by category, you are claiming:

\$ \_\_\_\_\_  
 Health Care Flex Account

\$ \_\_\_\_\_  
 Dependent Care Flex Account

\$ \_\_\_\_\_  
 Other

\_\_\_\_\_  
 Employee Signature/*Firma de Empleado*

\_\_\_\_\_  
 Date/*Fecha*

Remember, your claim must include information that indicates the date the services were performed, the type/nature of the expense, the provider information, the amount you are responsible for, and the name of the person the expense was incurred for. It must include the name and tax id# of the provider if it is for dependent care expenses.

*Para procesar su reembolso, su documentacion debera incluir lo siguiente: La fecha del servicio; el nombre de la persona por la cual el servicio fue proveido; el tipo o naturaleza del gasto; el nombre y direccion del proveedor; and el total del gasto por el cual usted es responsable. Gracias*