PLEASE MAIL/FAX TO: **FCF Benefits & Administration**
2494 E. Kays Creek Dr.
Layton, UT 84040
Fax – (801) 683-3595
E-mail : claims@fcfinc.com

NOTE: **For claims questions, call claims dept. @ 801- 939-4900 x 206**

Dear Employee:

Following is a claim form to receive reimbursement for your out-of-pocket medical expenses for your Flexible Spending Account(s). Please note that each item should be listed separately and the receipt attached for each reimbursable item. **Each receipt must show the original date of service and the type of service provided.** Please keep a copy of each receipt for your records.

UNREIMBURSED MEDICAL EXPENSE

(MEDICAL EXPENSES FOR YOU OR ANY TAX DEPENDENT)

Instructions: Fill in the necessary information below for the medical expenses incurred by you or by your eligible dependents for which you request payment. An original receipt showing date of expense or an explanation of benefits from your insurance carrier must accompany each expense item.

Date Expense Incurred	Service Provider (i.e. Clinic, Doctor, Pharmacy, Store, etc.)	Description of Expense	Amount Paid Total Expense	Amount Paid By insurance (if any)	Amount Paid By you

Total Unreimbursed Medical Claim $_____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, MY STATEMENTS IN THIS REIMBURSEMENT REQUEST FORM ARE COMPLETE AND TRUE. I AM CLAIMING REIMBURSEMENT ONLY FOR ELIGIBLE EXPENSES INCURRED DURING THE APPLICABLE PLAN YEAR. I CERTIFY THAT THESE EXPENSES HAVE NOT BEEN PREVIOUSLY REIMBURSED UNDER THIS OR ANY OTHER BENEFIT PLAN AND WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.

_____ _____ _____

SIGNATURE OF EMPLOYEE Date

_____ (____)_____ _____

Please Print Name Day Time Phone Number Your Employer

E-mail Address:_____