Flexible Spending Plan Reimbursement Voucher

*Please read the back of this form for instructions on how to complete this voucher *

Name of **EMPLOYER**

YOUR Name S.S. Number

YOUR Address **(CHECKS WILL BE SENT TO THIS ADDRESS)** City State Zip

☐ **PLEASE CHECK THIS BOX IF THERE IS A CHANGE OF ADDRESS.**

Home Phone # Work Phone #

Unreimbursed Medical Expenses

(Office Visits, Co-Pays, Vision, Dental, etc.)

Receipt must include Nature of Service, Date of Service, and Amount

Dependent / Child Care Expenses

(Day Camps, Babysitters, Daycare Centers, etc.)

Receipt must include Date of Service, Amount, and SS# or Tax ID#

☎ **Prescription for item # on file with PGP:** ☐

Nature of Service	*Date(s)*	*Amount*
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
	TOTAL	**$**

Name of Day Care Provider	*SS# or Tax ID #*
1	
2	

Description of Service	*Date(s)*	*Amount*
1		$
2		$
3		$
4		$
5		$
	TOTAL	**$**

Premium Expenses

(Privately held insurance policies)

Description of Service	*Dates of Service*	*Amount*
1		$
2		$
	TOTAL	**$**

This is to certify that I have incurred the expenses listed above for myself or qualifying dependents and that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans. I have enclosed copies of all bills for these expenses, including documentation of reimbursement to me, if any, provided by other health coverage. I have retained originals or copies of all documents submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed for my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, and the funds shall be re-credited to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

X

SIGNATURE ***Date***

Send completed vouchers to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(518) 641-0321 (800) 573-7474
Fax: (518) 641-0325

Minimum Request:$25.00

☎ **SEE REVERSE FOR DETAILS**