

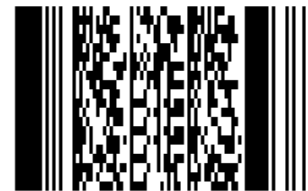
LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

A. ACCOUNT HOLDER INFORMATION -- COMPLETE FOR ALL CLAIMS (PLEASE PRINT CLEARLY)				
Employer Name:		This claim applies to the plan year ending on:		
Employee Name:	Last:	First:	Middle Initial:	
Mailing Address:	Street:	City:	State:	Zip:
Social Security Number or Employee ID:		E-Mail Address:		

B. Limited Purpose Flexible Spending Account --- Vision & Dental Expenses Only					
Item #	Patient's First Name	Relationship to Employee	Date(s) of Service <small>(example: 05/25/21 or 01/01/21 to 05/09/21)</small>	Service Provider <small>(Doctor's Name, Pharmacy Name, etc)</small>	Amount of Claim
H1					\$
H2					\$
H3					\$
H4					\$
H5					\$
H6					\$
H7					\$
H8					\$
H9					\$
H10					\$
Total Amount					\$

PARTICIPANT'S STATEMENT AND SIGNATURE (PLEASE READ CAREFULLY)	
<p>To the best of my knowledge and beliefs, my statements in this Reimbursement Request Form are complete and true. I certify that I or my family member has received the service described above on the dates indicated and that expenses qualify as valid expenses under the Plan and that I have not been previously reimbursed by this or any other plan nor do I expect any of these expenses to be reimbursed elsewhere. A copy or electronic facsimile of this form shall be deemed as valid as the original.</p>	
Plan Participant's Signature 	Date

Mail or Fax all requests to:
 HR Simplified, Inc., PO Box 56021, Boston, MA 02205
 Toll-Free Phone: (888) 318-7472 Toll-Free Fax: (877) 723-0146



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