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(Company Name)

# FLEXIBLE BENEFIT PLAN
# REIMBURSEMENT REQUEST

Employee Name:________________________________ Social Security #:____________________

Address:________________________________________________________________________
Street City ZIP

Is this a new address? YES NO (circle one)

## MEDICAL/DEPENDENT CARE EXPENSES INCURRED

| DATE INCURRED | NAME OF PROVIDER | DESCRIBE EXPENSE | NAME/RELATION OF WHOM INCURRED EXPENSE | NET AMOUNT |
|---|---|---|---|---|
| ______ | ______________ | ___________________ | ____________________________ | $_______ |
| ______ | ______________ | ___________________ | ____________________________ | $_______ |
| ______ | ______________ | ___________________ | ____________________________ | $_______ |
| ______ | ______________ | ___________________ | ____________________________ | $_______ |
| ______ | ______________ | ___________________ | ____________________________ | $_______ |

**TOTAL $______**

(OVER FOR ADDITIONAL CLAIMS)

**READ CAREFULLY:** THE UNDERSIGNED PARTICIPANT IN THE PLAN CERTIFIES THAT ALL EXPENSES CLAIMED ON THIS FORM WERE INCURRED DURING THE PLAN YEAR WHILE THE UNDERSIGNED WAS COVERED UNDER THE FLEXIBLE BENEFIT PLAN WITH RESPECT TO SUCH EXPENSES AND THAT THESE EXPENSES HAVE NOT BEEN REIMBURSED, OR ARE NOT REIMBURSABLE UNDER ANY OTHER BENEFIT PLAN.

THE UNDERSIGNED UNDERSTANDS THAT HE/SHE ALONE IS FULLY RESPONSIBLE FOR THE SUFFICIENCY, ACCURACY, AND VALIDITY OF ALL INFORMATION RELATING TO THIS CLAIM. EACH EXPENSE FOR WHICH PAYMENT OR REIMBURSEMENT IS CLAIMED MUST BE A PROPER EXPENSE UNDER THE PLAN. IF NOT, THE UNDERSIGNED MAY BE LIABLE FOR THE PAYMENT OF ALL RELATED TAXES INCLUDING FEDERAL, STATE OR CITY INCOME TAX ON AMOUNTS PAID.

THE UNDERSIGNED FURTHER UNDERSTANDS THAT **NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE.** THE UNDERSIGNED AUTHORIZES HIS/HER OWN ACCOUNT TO BE REDUCED BY THE AMOUNT REQUESTED.

**EMPLOYEE'S SIGNATURE:______________________________________DATE:____________**

## ATTACH RECEIPT

**CANCELLED CHECKS OR BALANCE DUE STATEMENTS ARE NOT ACCEPTABLE RECEIPTS.** RECEIPT(S) FOR HEALTH EXPENSES MUST SHOW: DOCTOR OR PROVIDER OF SERVICE, DATE OF SERVICE, AMOUNT AND PERSON FOR WHOM THE SERVICE WAS RENDERED. PRESCRIPTION RECEIPTS MUST SHOW DATE, DOCTOR, NAME OF PATIENT AND TYPE OF MEDICATION. YOU MUST ALSO SUBMIT THE APPROPRIATE EXPLANATION OF BENEFITS FROM YOUR INSURANCE PLAN IF APPLICABLE.

**MAIL TO:** **NICO INSURANCE SERVICES, INC.**
7290 NAVAJO ROAD, SUITE 111
SAN DIEGO, CA 92119
CA Agency License No. 0790551
(619) 667-2111 FAX (619) 667-2100
e-mail: stephanie.seaman@nico-ins.com

| DATE INCURRED | NAME OF PROVIDER | DESCRIBE EXPENSE | NAME/RELATION OF WHOM INCURRED EXPENSE | NET AMOUNT |
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**TOTAL** $__________