Hewitt, Coleman & Associates
PO Box 6708 Greenville, South Carolina 29606
(888) 298-6828 fax: (864) 467-9489
customerservice@bsicompanies.com

FLEXIBLE BENEFITS PROGRAM CLAIM FORM

GROUP:		**GROUP#:**	
EMPLOYEE NAME:		**SOCIAL SECURITY #:**	

Please indicate below the amount of expenses you are claiming. Attach itemized receipts and retain copies for your files. If you have other medical, vision and/or dental coverage you must send a copy of an explanation of benefits (EOB) from your medical, vision and/or dental carrier to receive reimbursement.

If you do not have any other medical, vision and/or dental coverage for yourself and/or dependent(s) you must indicate by checking here. ( )

MEDICAL REIMBURSEMENT			
DATE OF SERVICE	**PATIENT**	**DESCRIPTION**	**AMOUNT**
		CLAIM TOTAL	**$**

(Please be sure to specify under the description what the service or supply is that you are submitting for reimbursement.)

I understand that the use of this service or supply is strictly to be used by my family or myself. I certify that this information is correct, complete and meets all requirements for eligible healthcare expenses.

Employee's Signature: **Date:**

DEPENDENT CARE REIMBURSEMENT	
DEPENDENT NAME	
AMOUNT	
DATES OF SERVICE	
DAYCARE PROVIDER NAME	
DAYCARE PROVIDER TAX ID#	

I also certify that the total Dependent Day Care expenses (if any) for which I am requesting reimbursement do not exceed the lesser of my or my spouse's earned income for the plan year. I understand that reimbursed expenses cannot be claimed on my personal income tax return. Also, any unused funds in my account at the end of the plan year will be forfeited. I certify that this information is correct, complete and meets all requirements for eligible dependent care expenses.

Employee's Signature Date

If you have any questions or concerns, please fill free to call the number listed above.
For faster reimbursement, please send completed claim form and receipts to customerservice@bsicompanies.com