

SECTION 125 FLEXIBLE SPENDING



Corporate Systems Administration, Inc.
P.O. Box 4985 CRS
Johnson City, Tennessee 37602

REIMBURSEMENT REQUEST FORM

EMPLOYER NAME		BRANCH LOCATION		GROUP NUMBER	
EMPLOYEE'S LAST NAME		FIRST	M.I.	BIRTHDATE	MALE
				/ /	FEMALE
ADDRESS		STREET		SOCIAL SECURITY NUMBER	
<input type="checkbox"/> CHECK HERE IF NEW					
CITY		STATE	ZIP	IF NAME CHANGE, GIVE FORMER NAME	

	AMOUNT
PREMIUM REIMBURSEMENT SUBMISSION	\$ _____
CHILD CARE REIMBURSEMENT SUBMISSION	\$ _____
CLAIM EXPENSE OUT-OF-POCKET SUBMISSION	\$ _____

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO VALIDATE ALL REIMBURSEMENT SUBMISSIONS. DOCUMENTATION MUST BE A COPY OF THE BILLING, A RECEIPT WHICH INDICATES THE PERFORMANCE AND PAYMENT OF THIS SERVICE, OR A COPY OF AN EXPLANATION OF BENEFITS FORM FROM YOUR MEDICAL CARRIER.

I VALIDATE THAT THE REQUESTED REIMBURSEMENTS ARE ACCURATE AND ALL SERVICES HAVE BEEN COMPLETED.

SIGNATURE _____ DATE _____