SECTION 125 FLEXIBLE BENEFIT PLAN
EXPENSE REIMBURSEMENT VOUCHER

Name of Employer:		Daytime Phone (with area code):
Name of Employee (Last, First, M.I.):		Social Security #:
Address:	City & State:	Zip Code:
Is this a New Address? Yes / No	*****Email Address (print clearly):	

*** You will receive notification by e-mail when your claim is received and another when a payment is sent. You will also receive e-mail notification of direct deposits. Please be sure your e-mail address is legible.***

Date of Service	Description of Expense	Family Member for Whom Expense Was Incurred	Amount of Expense	
			Medical Expense	Dependent Day Care
TOTAL			**$0.00**	**$0.00**

UNREIMBURSED MEDICAL (URM) EXPENSE GUIDELINES: With the expense voucher, you will need to submit a professional bill or receipt that includes the following: 1) Service provider's name; 2) Type of service rendered; 3) Charge for service; and 4) Original date of service. Note: the date of service, NOT the date of payment, must fall within the dates of the Section 125 plan year (or grace period, if applicable) for which you are enrolled. When submitting a claim for orthodontia, you must provide a copy of the service contract with your first reimbursement request. Receipts for service should include a detailed description of the service. Acceptable documentation of an expense includes an insurance company's explanation of benefits or a pharmacy statement with an Rx number and name of prescription. Unacceptable documentation includes cancelled checks, credit card receipts or a statement or bill that shows a balance forward, previous balance or payment due.

DEPENDENT DAY CARE (DDC) EXPENSE GUIDELINES: You must submit a completed Dependent Day Care Acknowledgment Form with the expense voucher for reimbursement.

*****INCOMPLETE VOUCHER OR ACKNOWLEDGMENT FORMS MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM*****

I authorize the above expense(s) to be reimbursed from my medical expense and/or dependent day care reimbursement account(s), whichever applies. To the best of my knowledge, my statements on this form are true and complete. I certify all of the following: Either I, my Spouse, or my Dependent has received the services described above on the dates indicated and the expenses qualify as valid medical care expenses under Code Section 213(d) . If I am a participant of a Health Savings Account and am also covered under a Limited Purpose medical expense account, the above expenses qualify as being services that are eligible under the account. These expenses have not previously been reimbursed under the medical expense or dependent care reimbursement account or any other health plan and I will not seek reimbursement for them under my medical insurance or any other health plan. I understand that expenses for cosmetic purposes, toiletries or for general good health do not constitute an eligible expense. I understand that expenses reimbursed may not be used to claim any federal income tax deductions or credit. I also understand that I may be asked to provide further details about some expenses, such as a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me.

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Date Signed Signature of Employee

Mailing Address: American Fidelity Assurance, Flex Account Administration, P. O. Box 25510, Oklahoma City, OK 73125

Fax Number: (800) 543-3539. American Fidelity will not be responsible for faxes not received. Average processing time is 5 to 7 working days from receipt of a completed voucher. Additional Forms and Account Information are available on our website at**:** **www.afadvantage.com®**

FlexConnection® Interactive Phone Response Number: (800) 325-0654