UNIVERSITY MEDICAL CENTER

MEDICAL FSA CLAIM FORM

For Plan Year _____

EMPLOYEE FLEXIBLE BENEFIT PLAN

EMPLOYEE: _____

MEDICAL FSA EXPENSE → **$**_____

Please indicate the amount of expense you incurred for the item above since the last Expense Report. Your Reimbursement Check will be sent at the end of the month that it is claimed.

**I acknowledge that I have attached supporting documents such as receipts, vouchers, etc. to corroborate the expenses listed above. I also understand that any unused salary reductions (for each expense item) will be forfeited at the end of the Plan year. I understand that any expenses for which I am reimbursed under this Plan may not be claimed as income tax deductions.
By signing below I certify that the expenses listed above have not been reimbursed, and are not reimbursable, under any other health plan coverage; and I certify that the expenses listed above have not been submitted to this Section 125 Plan previously, or to any other Plan in which I or my spouse are covered.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

_____ _____
Signature Date

Prepared by Chris Mabry
Pension Concepts & Administration, Inc.
Cafeteria Plan Department
2811 74th Street, Ste. A
Lubbock, TX 79423
cmabry@pensionconcepts.org
806-745-9781 x.6
806-745-9783 fax