FAX: (203) 270-0927
EMAIL TO: sthompson@trpaul.com
MAIL TO. TR PAUL INC.
555 Heritage Road
SOUTHBURY CT 06488
PHONE (800) 678-8161 Ext. 257

Number of pages faxed_____

TR Paul Inc.

FLEXIBLE BENEFITS REQUEST FOR REIMBURSEMENT

EMPLOYEE NAME:	EMPLOYER:	
STREET ADDRESS	Ss# (LAST 4 DIGITS ONLY)	EMAIL ADDRESS:
CITY, STATE, ZIP	IS THIS A NEW ADDRESS? YES NO	

INSTRUCTIONS: Please complete the information below for medical expenses incurred by you, your spouse or other eligible dependents. Photocopies are acceptable if they are legible. Only the following documents will be accepted: For office visit copays: a Copay receipt from the doctors office OR the Explanation of Benefit form from the insurance carrier. For copays on prescriptions: The pharmacy receipt OR a computer print out from the pharmacy OR the RX receipts from the cash register. All other expenses must be documented with the Explanation of Benefit form from your insurance carrier(s). Do not send cancelled checks, billing statements, previous balance statements or charge card receipts.

Please indicate if the claimant has:	Medical Insurance YES NO	Dental Insurance YES NO	Vision Insurance: ___Exam & Glasses or exam only ___No Vision Coverage

A. HEALTHCARE REIMBURSEMENT REQUEST: (copays, deductibles, co-insurance amounts, over-the-counter).

When totaling the reimbursement amount, do not include amounts reimbursed by any other source.

Date of Service	Patient Name	Relation to Employee	Description of Expense	Reimbursement Amount

B. DEPENDENT DAY CARE REQUEST

Name of Dependent	Birth Date	Dates of Service	Name & Address of Provider	**Tax ID #**

This statement requires your signature and applies to Health Care and Dependent Day Care Expenses:

I certify that I, or my eligible dependents have incurred health care and/or dependent day care expenses. Furthermore, I declare that these expenses have not been reimbursed or are not reimbursable through any insurance benefit plan and will not be deducted on my federal, state or local income tax returns. I will not seek reimbursement under any other health plan or flex plan. Any medical expenses listed above were incurred for treatment, diagnosis or mitigation of a disease or illness. I am not submitting any expense that are toiletries, cosmetic or expenses that are not medically necessary. I understand expenses for general good health are not eligible for reimbursement.

SIGN AND DATE BELOW:

_____ _____