

Flexible Spending Reimbursement

Creative Plan Administrators

330 Roberts Street
 East Hartford, CT 06108
 Fax (860) 656-7982

Employer / Employee Information

Employer: _____ **Group No. :** _____
Last Name: _____ **First Name:** _____ **MI:** _____
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Identification Number: _____ **Plan Year:** _____

Medical Reimbursement Account

Patient Name	Services Provided By	Date Incurred	Type of Expense	Reimbursement Requested
				\$
				\$
				\$
				\$

Total Reimbursement Requested = \$

Dependent Care Account

Services Provided By	Taxpayer ID Number	Date Incurred From To	Dependent's Name	Reimbursement Requested
				\$
				\$
				\$
				\$

Total Reimbursement Requested = \$

Supporting documentation must be attached to validate all reimbursement submissions. Documentation must include a copy of an explanation of benefits form from your medical carrier and proof of payment or a copy of an invoice or receipt indicating the date of service.

I validate that the requested reimbursements are accurate and all services have been completed, paid, and are not payable by insurance coverage or any other plan.

Participant's Signature _____ **Date** _____