Benefit Administrators, Inc.
1250 Tower Lane
Erie, PA 16505

Phone: (814) 454-0167
Fax: (814) 461-9402

FLEXIBLE SPENDING PLAN
CLAIM SUPPORTING STATEMENT

Employer's Name	
Employee's Name	**SSN** (last four)
Address	
Email	

Enclosed are copies of all supporting documents, receipts, vouchers, etc., to document the expenses listed below. The original receipts have been retained for my records.

Medical/Dental/Vision Reimbursements	$
Dependent Care Reimbursements (day care)	$

Any unused amounts in my account will be forfeited back to my employer at the end of the plan year, including any runout period, as provided in the plan document. I certify that I have not requested reimbursement under this plan or from any other source for these charges.

I CERTIFY that the above information is correct and complete.

Signature Date

PLEASE KEEP A COPY OF THIS CLAIM FORM AND SUBMITTED RECEIPTS FOR YOUR RECORDS

Submit your claim(s) one of three ways:

Email: thr.hb.FSA@hubinternational.com, **Fax:** 814-461-9402, **USPS: BAI: Spending Account, 1250 Tower Lane, Erie, PA 16505**

STOP!

BEFORE YOU SUBMIT YOUR FSA OR DEPENDENT CARE CLAIM(S), PLEASE TAKE A MOMENT TO VERIFY THAT ALL OF YOUR DOCUMENTATION SATISFIES THE FOLLOWING REQUIREMENTS; OTHERWISE, YOUR ENTIRE CLAIM MAY NOT BE PROCESSED IF IT HAS TO BE REUTRNED FOR INSUFFICIENT DOCUMENTATION.

1. Provider/Merchant Name
2. Patient/Dependent Name
3. Date(s) of Service (NOT date of payment)
4. Description of Service/Purchase
5. Amount owed/due/paid

*Cash register receipts are only accepted for over the counter (OTC) purchases alone. Prescriptions, office visits, and any other reimbursement requests must be accompanied by an itemized statement, Rx "bag tag", or Explanation of Benefits (EOB) to include all five of the pieces of information above.

Please list the FSA eligible expenses for reimbursement

Date of Service	Claim Type	Amount
TOTAL		$ 0.00