Employee Benefits Group

Flexible Benefit Plan Reimbursement Claim Form

Company: _____

Employee Name: _____

Home Address: _____
Street City State Zip

Phone: _____ **E-Mail:** _____

Please attach all receipts to this form.

NOTE: The IRS no longer accepts canceled checks or credit card charge slips as sufficient proof of claim. Therefore, documents showing date, cost, and description of service are required for reimbursement.

Daycare Expense Claims:

Name Of Dependent(s)	Date Of Service	Service Provider Name, Address and Tax ID#	Amount
		Total Daycare Expenses $	

Unreimbursed Medical Expense Claims:

Date of Service	Service Provider with Brief Description	Person Expense Covers	Amount
		Total Medical $	

Read Carefully:

The above is true and accurate statement of unreimbursed medical / dependent care expenses and / or individually owned health insurance premiums incurred by me or my eligible dependents on the date(s) indicated, and were incurred while I was covered under the said company's Flexible Benefit Plan. Receipts from my service provider(s) and / or insurance carrier(s) for all expenses and / or individually owned health insurance premiums claimed by me are attached to this voucher. I understand that theses expenses cannot be submitted to any other medical plan once reimbursed under this Plan. I also understand that I cannot claim my reimbursed expenses on my income tax return, and that I may be liable for payments for all related taxes including Federal, State or City income tax on the amounts paid for any expense improperly claimed under the Plan.

Signature: _____ **Date**: _____

Send claims to: **CGI Employee Benefits Group**
Claims Processing Department
171 Londonderry Turnpike
Hooksett, NH 03106

Or Fax Claims to: 603-232-9363
Or E-mail to : claims@cgibenefitsgroup.com

For CGI Use Only:

Claim received: _____ Processed by: _____

Amount of payment: _____ Payment date: _____