Employee Benefits Group

*my*SourceCard™ SUBMITTAL FOR RECEIPTS

Please ONLY use this form to submit receipts for *my*SourceCard™ purchases.
Please use the Manual Claims Form for claims when check reimbursement is necessary.

FULL NAME: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

COMPANY NAME: _____

WORK PHONE NUMBER: _____ EMAIL ADDRESS: _____

Please attach all receipts for expenses incurred using the *my*SourceCard™. You are not required to submit receipts for the following claims: Doctor Visit Co-Pay and/or Prescription Drug Co-Pay amounts. Please, however, have these receipts available if requested.

IMPORTANT NOTE: Please keep copies of your original receipts for your personal records.

Fax To: **CGI Employee Benefits Group**
Attn: Benefits Administration
Fax: (603) 232-9363
Phone: (603) 622-4600
Toll Free: (866) 841-4600

Mail To: **CGI Employee Benefits Group**
Attn: Benefits Administration
171 Londonderry Turnpike
Hooksett, NH 03106

The attached receipts are a true and accurate account of medical, dependent care expenses and / or individually owned health insurance premiums incurred by me or my eligible dependent(s) on the date(s) indicated, and were incurred while I was covered under the said company's Flexible Benefit Plan. I understand that these 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. I understand 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. I also understand that if these claims are not proven to be true and accurate, *my*SourceCard™ is subject to deactivation and I am responsible to reimburse the Plan for such claims.**

_____ _____
Signature **Date**

Do Not Use This Form When Submitting Manual Claims.

Please Submit This Form with All Faxed or Mailed *my*SourceCard™ Receipts