

Complete this form to receive reimbursement from your Health Reimbursement Arrangement(HRA) and/or Flexible Spending Account. You MUST attach documentation/Explanation of Benefits(EOB) to receive reimbursement. If you are not in the FSA, please disregard the bottom section of this form entitled "Flexible Spending Account". If you are in the Flexible Spending Account and a filing a Health Reimbursement Arrangement Claim, and would like to be reimbursed from the FSA for expenses you are responsible for paying, please indicate this on the top of the claim form entitled "Health Reimbursement Arrangement" under the column entitled "Reimburse your portion from FSA" If you mark yes we will determine the amount of the claim that is due from HRA and the amount that is due from FSA.

Employee/Participant Information

Employee/ Participant Name	Employee Social Security #
Employer/ Company Name	
<input type="checkbox"/> Change of Address Home Address	City, State Zip
** Email Address	Contact Phone

Health Reimbursement Arrangement

Date(s) Incurred	Description of Expense	Name of Family Member	Relationship to Employee	FSA debit card used?	Expense Amount	Reimburse your portion from FSA?
				Y N	\$	Y N
				Y N	\$	Y N
				Y N	\$	Y N
				Y N	\$	Y N
Total					\$	

Flexible Spending Account

Date(s) Incurred	Type of Expense*	Description of Expense	Name of Family Member	Relationship to Employee	FSA debit card used?	Expense Amount
	H D				Y N	\$
	H D				Y N	\$
	H D				Y N	\$
	H D				Y N	\$
Total						\$

* H = Healthcare expense (Dental, Vision, Rx, etc.), D = Dependent care expense (day care)
 You will need to complete a **Dependent Care Verification Form** for any dependent care expenses.

Authorization

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's cafeteria plan with respect to such expenses and that the medical expenses have not been reimbursed, or are not reimbursable under any other health plan coverage. The Dependent Flexible Spending Account is used for dependent care expenses that allow you (or you and your spouse if married) to work or look for work or that allow your spouse to attend school full time. The care may be provided inside or outside your home. For more details, please refer to your Summary Plan Description. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. If a fraudulent claim is filed, you will be responsible for paying back the fraudulent claim.

Signature	Date
Print Name	

Fax this form and receipts to (866) 209-3517, E-mail form to flex@swerdlin.net, or mail to Swerdlin & Company, 5901 Peachtree Dunwoody Road, B-100, Atlanta, GA 30328. For questions, please call (866) 687-4015. For balance inquiries, visit www.swerdlin.net

You must attach receipts for the above incurred expenses to this form.

**Please provide an Email Address if you would like to receive email notifications from Swerdlin, including notifications when we receive your claims.