SISCO
Experience the Benefits

Flexible Spending Reimbursement Request Form

Participant Name:_____ Date of birth:_____

Participant ID#:_____ Group #:_____

MEDICAL/DENTAL/VISION EXPENSES -- ATTACH EOBS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				
6				
7				
8				

DEPENDENT CARE -- ATTACH EOBS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or from any other source.
- All health/daycare expenses listed above comply with the requirements and guidelines listed in the Flexible Spending plan document.

Signature_____ (Date) ____/____/_____

KEEP A COPY FOR YOUR FILES

Mail: Flexible Spending Dept., SISCO, P.O. Box 389, Dubuque, IA 52004-0389

Fax: 563-587-5703 Email: siscoflex@siscobenefits.com

Claims must be received at SISCO, two (2) business days before your scheduled flexible spending run.