STERLING C.U.S.D. #5

Medical Expense Flexible Spending Account Claim Form

MAIL CLAIMS TO:

Butler Benefit Service, Inc.
P.O. Box 3310
Davenport, IA 52808-3310

KEEP A COPY OF THIS CLAIM FOR YOUR FILES!

Employee Name	Employee SSN or Plan ID Number

UNREIMBURSED MEDICAL EXPENSES (attach EOBs or receipts to this claim form)

Patient Name	Dates of Service	Name of Healthcare Provider	Reimbursement Requested
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		Total Reimbursement Requested:	***$***

To be included in a scheduled processing cycle, claims must be received at BBSI at least 4 FULL business days beforehand; claims received after this time may be delayed until the next scheduled processing date.

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 care expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Packet.

Employee Signature (required)	Date