WIMBERLY ASSOCIATES, INC.

Flexible Spending Account Claim Form

150 Cunningham Pond Rd. | Peterborough, NH 03458
Phone: 877-884-6582 | Fax: 888-653-6034
Balances: 913-789-4600 | Web: wimberlyassociates.com

Employer: _____

Employee: _____

SSN: XXX-XX-_____

Date Incurred	Service Provider	Expense Description	Person For whom Expense Incurred	Net Amt
Total Amount of Claim				*$*

All payments from your plan must be reimbursements for expenses you incurred during the Plan Year. This means that you must provide us with proof of your expense (actual date of service and description). For example, receipts and copies of your expenses should be submitted with your claim. The undersigned participant in the Plan certifies that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Section 125 Plan with respect to such expenses and that the medical expenses have not been reimbursed under other health plan coverage. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim 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 all related taxes on amounts paid which relate to such expense.

Employee's Signature: _____ Date: _____