

Flexible Spending Account (FSA) Reimbursement Form

Please complete this form and mail or fax with supporting documentation to:
GREAT-WEST HEALTHCARE, FLEXIBLE BENEFITS ADMINISTRATION - PO BOX 1080 - DENVER - CO - 80201, or fax # 303-737-5248.
Please DO NOT mail and fax the same claim. Our Customer Service Representatives are available 7am to 5pm Mountain time at 800-759-4952.

Employer Name: _____ Group/Plan Number: _____
Employee Name: _____ Social Security Number: _____
Employee Mailing Address: _____
City/State/Zip Code: _____ Address Change? Yes No

Health Care Expenses (all information must be completed):
(Please attach itemized receipts or Explanation of Benefits (EOB) statements for the below services.)

Date of Service	Provider	Patient	Description of Service	Requested Amount
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____

Please use back of form if additional space is needed.
Total Amount Requested from Health Flexible Spending Account \$ _____

Dependent Care Expenses (all information must be completed):
(Day Care Provider MUST sign form OR itemized Day Care receipts MUST be attached.)

Name of Day Care Provider: _____
Address of Day Care Provider: _____
Tax ID Number OR Social Security Number of Day Care Provider: **(Required)** _____
Signature of Day Care Provider: _____

Dependent's Name	Date of Birth	Relationship	Dates of Service		Requested Amount
			From	To	
_____	___/___/___	_____	___/___/___	___/___/___	_____
_____	___/___/___	_____	___/___/___	___/___/___	_____
_____	___/___/___	_____	___/___/___	___/___/___	_____

Please use back of form if additional space is needed.
Total Amount Requested from Dependent Care Flexible Spending Account \$ _____

Employee Certification for Reimbursement:
I certify that I (and/or my spouse and/or eligible dependents) have incurred the expenses for reimbursement from my FSA. These expenses were not reimbursed, and are not reimbursable by any other benefit plan. To the best of my knowledge and belief, these expenses are eligible for reimbursement under my FSA. I (we) will not claim the expenses reimbursed through my FSA as deductions or credits when filing my (our) tax return.

Employee Signature: _____ Date: ___/___/___
(Signature Required)

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