

# Flexible Spending Account Disbursement Form (Do Not Use for HSA or HRA Disbursements)

## Employee Information *(please print)*

Name \_\_\_\_\_ SSN # \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please reimburse me  Please pay my provider (attach provider invoice) *IMPORTANT: For all claims listed, you must attach supporting documentation (such as receipts) that include: Provider's Name, Provider's Address, Amount Billed, Service Provided, and Actual Dates of Service. (Note that dates of payment are not sufficient.)*

### MEDICAL EXPENSES

*(Attach supporting documentation)*

PERSONS FOR WHOM EXPENSE WAS INCURRED	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	DESCRIPTION OF EXPENSE	AMOUNT
<b>TOTAL MEDICAL EXPENSES</b>				

### DEPENDENT CARE / DAYCARE EXPENSES

*(Attach supporting documentation)*

DEPENDENT INFORMATION (NAME, AGE, RELATIONSHIP)	DATE(S) COVERED	NAME & ADDRESS OF SERVICE PROVIDER	PROVIDER'S TAX ID OR SSN	AMOUNT
<b>TOTAL DEPENDENT CARE/DAYCARE EXPENSES</b>				

### Read Carefully

I certify that I am a participant in the Flexible Spending Account (FSA) Plan and confirm that these expenses, for which reimbursement is requested, have been incurred during the Plan Year while I was covered under the FSA Plan. These expenses have not been reimbursed by any other benefit plan. I understand that I am responsible for the validity of this request and all information pertaining to it. I further understand that I am liable for all related Federal, State or City taxes for any invalid request submitted by me and I will not claim credit for reimbursed expenses on my individual tax return.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

**Mail To:** Sterling HSA, P.O. Box 71107, Oakland, CA 94612  
**Email To:** customer.service@sterlinghsa.com | **Fax To:** 888-410-7361