Health & Wellbeing Benefit Form
BENEFIT CHOICE AND REQUEST FOR REIMBURSEMENT

I. Participant Name: _____
(please print neatly or type)

Social Security Number: _____ - _____ - _____

II. Benefit Choices:
_____ 401(k) Contribution (Pretax) – See HR or Payroll.
_____ Medical Spending – Flexible Spending Account (Pretax)
_____ Dental or Vision Discount Plan (Post tax)
_____ Glasses or Vision Care (Post tax)
_____ Dental Costs (Post tax)
_____ Gym Membership (Post tax)
_____ Identity Theft Insurance (Post tax)

III. Invoices attached
(please attach a separate sheet if more space is needed)

Date of Service	Provider	Amount
_____	_____	$_____ . ___
_____	_____	$_____ . ___
_____	_____	$_____ . ___

III. Total Amount Requested $_____ . ___

IV. Statement by Participant
The medical expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other health plan coverage, including other medical flexible spending arrangements.

_____ _____
Participant's Signature Date

All requests for reimbursement submitted through payroll, must be accompanied by a receipt which indicates the following:

1. Name of person receiving service
2. Date of service (current year)
3. Description of service
4. Amount ($) of service

Receipts must show date of payment (current year).

All receipts that are submitted with the appropriate reimbursement form by 10AM Monday will be reimbursed on Thursday's paycheck.