SISCO
Experience the Benefits

Flexible Spending Reimbursement Request Form

Participant Name: _____ Date of Birth:_____

Participant ID#: _____ Group #: _____

MEDICAL/DENTAL/VISION EXPENSES -- ATTACH EOBS OR ITEMIZED RECEIPTS W/CLAIM FORM

Item	Participant/Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				
6				
7				
8				

DEPENDENT CARE – ATTACH RECEIPTS W/CLAIM FORM

Item	Dependent Name	Date(s) of Service	Care Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				

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/daycare expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Plan Document.

Signature _____ (Date) _ ___/_____/

KEEP A COPY FOR YOUR FILES

Mail: Flexible Spending Dept., SISCO, P.O. Box 1542, Dubuque, IA 52004-1542

Fax: 563-207-7300 Email: RAServices@siscobenefits.com

Claims must be received at SISCO two (2) business days before your scheduled flexible spending run.