**Southeast Dubois County School Corporation**

Wellness Benefit Claim Form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Please type or clearly*** |  |  |  |  |
| Employee Name: |  |  |  |  |
| Address: |  |  |  |  |
|  |  |  |  |  |
| Telephone: |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature: |  |  |  |  |
| Date: |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| ***ELIGIBLE EXPENSES*** |  |  |  |  | |
|  | |  |  |  | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Description of Eligible Expenses** | **Expenses For\*** | **Date of Service** | **Total Amount of Bill** | **Amount Paid by Any Plan** | **Your Actual FSA Claim Cost** | |  |  |  | $ | $ | $ | |  |  |  | $ | $ | $ | |  |  |  | $ | $ | $ | |  |  |  | $ | $ | $ | |  |  |  | $ | $ | $ | |  |  |  | $ | $ | $ | | \* Name of patient | |  |  |  |  | |  | | **TOTAL REFUND REQUESTED:** | | | $ | | |  |  |  | |
|  | |  |  |  | |
|  | |  |  |  | |
|  | |  |  |  | |
|  | |  |  |  | |

**Please send this form to Dunn & Associates Benefit Administrators, Inc. ATTN: Lisa Kelley**

Email: lkelley@dunnbenefit.com

Mail to: PO Box 2369 Columbus, IN 47202-2369

Fax: (812) 378-9967