Southeast Dubois County School Corporation

FLEXIBLE BENEFIT PLAN
Claim Form For Healthcare Expenses

MAIL TO PLAN SUPERVISOR:
Dunn Benefit Administrators
P.O. Box 2369
Columbus, IN 47202
(812) 378-9960
(800) 880-9960

Part 1. Please type or print clearly

Employee Name: _____

Address: _____

_____

Telephone #: _____

Social Security Number: _____

Group/Employee Number: _____

Employment Date: _____

Part 2. List any health plans under which you and/or your dependents are presently covered:

	Plan Name	Coverage Type		Covered Persons
		Individual	Family	
( ) Your Health Plan	_____	☐	☐	_____
( ) Your Spouse's Health Plan	_____	☐	☐	_____
( ) Other Coverage	_____	☐	☐	_____

Part 3. SIGN/DATE

I certify that the expenses for which reimbursement is requested under my Flexible Benefit Plan were incurred by myself and/or my eligible dependents. I will not use expenses reimbursed through the Flexible Benefit Plan as deductions when filing my individual income tax return. I certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse or another member of my family.

_____ _____

Employee Signature Date

Part 4. ELIGIBLE EXPENSES

Expenses you have paid as your share of health costs, expenses not covered by your Employee Benefit Plan, or other tax deductible health expenses (verification attached).

Description of Eligible Expenses	Expenses For*	Date of Service	Total Amount of Bill	Amount Paid by Any Plan	Your Actual FSA Claim Cost
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$

* Name (if dependent, relationship and date of birth)

TOTAL REFUND REQUESTED: $