



# FLEXIBLE SPENDING ACCOUNT DISBURSEMENT FORM (DO NOT USE FOR HSA OR HRA DISBURSEMENTS)

## EMPLOYEE INFORMATION *(PLEASE PRINT)*

Name	SSN #	Email	Phone	Employer
Employee Address		City	State	Zip

Please change the address on my account to the above:  For this disbursement only  Permanently on my account

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				
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				<i>(Attach supporting documentation)</i>
DEPENDENT INFORMATION (NAME, AGE, RELATIONSHIP)	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	PROVIDER'S TAX ID OR SSN & DESCRIPTION OF EXPENSE	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, P.O. Box 71107, Oakland, CA 94612  
**Email To:** customer.service@sterlingadministration.com | **Fax To:** 888-410-7361