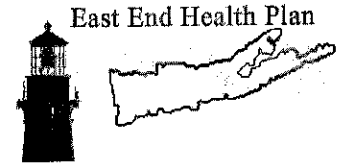


Return completed form to:  
**J.J. Stanis & Company, Inc.**  
 100 Jericho Quadrangle Suite 101  
 Jericho, NY 11753  
 Fax Number – 1-516 465 3920



# Request for Healthcare Reimbursement Expenses

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

Employee Name \_\_\_\_\_ SS No. \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
Number/Street City State Zip

Please check only if this is a new address. Daytime Telephone Number \_\_\_\_\_

### HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Check the box that applies. Supporting documentation as required by the IRS, applicable laws and/or your Plan must accompany this reimbursement request form.

- I have group health (medical, dental, vision) insurance for this expense. Attach a copy of the Explanation of Benefits (EOB) statement that you received from your insurance carrier showing how benefits were paid.
- I do NOT have insurance coverage for this expense. Submit an itemized statement showing the date of service, provider's name, services provided and the amount of the charge.
- I belong to an HMO. Submit a paid receipt for your copayments. For expenses not covered, submit an itemized statement.
- I am submitting expenses for orthodontia. With your first request, submit a copy of the Truth in Lending Statement (contract) itemizing the treatment period, down payment and monthly payments, and the amount covered by insurance, if any. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment.

Date of Service	For the Benefit of (Name and Relationship)	Description of Service	Provider of Service	Requested Amount

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you have questions about a claim, or the FSA program, please call (516) 465-3900 between 8:00 a.m. and 5:00 p.m. ET, Monday through Friday.

To access additional claim forms, please visit our website: [www.jjstanisco.com](http://www.jjstanisco.com)