

PLEASE READ THE INSTRUCTIONS ON THE BACK PRIOR TO COMPLETION.
 KEEP A COPY OF THIS FORM FOR YOUR RECORDS. SEND COPIES OF ORIGINAL RECEIPTS.

PERSONAL DATA

Name: _____ Home Phone: _____

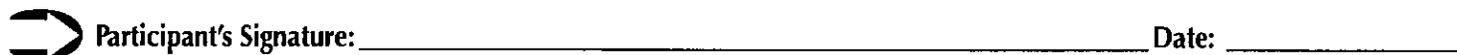
Street Address: _____ City: _____ State: _____ Zip: _____

SS#, Employee or FBMC ID Number: _____ Employer: _____ Day Time Phone: _____

PLEASE CHECK HERE IF THIS IS A NEW ADDRESS.

I understand, agree and certify to the following:

- I will use my FSA to only pay for IRS-qualified expenses, permitted under my Employer's plan(s), provided to me and my IRS-eligible dependents, on the date(s) indicated below as being incurred within my period of coverage under the applicable plan year.
- I will request reimbursement only after the services have been provided.
- I have not and will not seek reimbursement through any other source, and will exhaust all the other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my FSA.
- I specifically release my Employer and FBMC from any liability resulting from either my participation in any FSA or for any misrepresentation I make regarding my requests for reimbursement.
- I have read and understand the information on the front and back of this form.
- If I participate in my Employer's Dependent Care FSA Plan, I will file a Form 2441 with my income tax return and provide any taxpayer identification number required.
- The dependent care expenses I submit for reimbursement were incurred to allow me and my spouse (if married) to work or actively look for work.

 Participant's Signature: _____ Date: _____

(Required to process claim/reimbursement)

PAYMENT TYPE Place a check mark [✓] in the box(es) and fill in claim amount of any that apply below (**Medical FSA expenses ONLY**):

- A. I used the FBMC payment card to pay for these expenses - must attach documentation for transactions requiring documentation. † \$ _____
- B. Please pay me for these out-of-pocket expenses - documentation must be attached. † \$ _____
- C. Please apply attached documents as substitution toward card transactions requiring documentation. For lost documentation or substantiation of an ineligible charge † \$ _____

MEDICAL FSA Fill out completely (use for eligible medical expenses for yourself and qualifying dependents)

CHECK (✓) PAYMENT TYPE	Name of Person Receiving Service	Relationship to Employee	Provider of Services*	SERVICE DATE:**		AMOUNT THAT IS YOUR RESPONSIBILITY
				FROM:	TO:	
A. Card B. Pay me C. Sub. Docs						\$
						\$
						\$
						\$
						\$
TOTAL THIS PAGE						\$ 0.00
GRAND TOTAL FOR MULTIPLE PAGES						\$

DEPENDENT CARE FSA Fill out completely (use for childcare, dependent care and elder care services)

Name of Person Receiving Service	Relationship to Employee	Age and Grade	Name and Address of Persons or Facility Providing Service	SERVICE DATE:**		AMOUNT OF REIMBURSEMENT
				FROM:	TO:	
						\$
						\$
						\$
TOTAL THIS PAGE						\$ 0.00
GRAND TOTAL FOR MULTIPLE PAGES						\$

 SIGNATURE OF DAY CARE PROVIDER (LISTED ABOVE)
 OR ATTACH STATEMENT / BILL : _____

† Please remember to keep copies for your records.
 * "Provider of Services" means hospital, doctor, dentist, drugstore, medical supply store, etc.
 ** "Service date" refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it.