

FlexSystem™ REQUEST FOR REIMBURSEMENT

Client TASC Id 0000-0000-0000

Participant TASC Id 0000-0000-0000

Participant Name
 Participant Address
 Participant Address
 Participant City State Zip

PLEASE DUPLICATE THIS FORM FOR FUTURE REQUESTS

Submit Request for Reimbursement:

WEBSITE: www.tasconline.com

BY FAX: 608-663-2762

BY MAIL: TASC
 PO Box 7308
 Madison, WI 53707-7308

New Address, check here and update - please print

**USE BLACK INK ONLY
 ALL BOXES AND FIELDS MUST BE COMPLETED
 RETAIN ORIGINAL RECEIPTS FOR YOUR RECORDS
 ONLY FOUR LINES PER FORM WILL BE PROCESSED**

Receipt Attached	Date of Service (not billing or paid date)	Benefit Code	Service Type Code	Request Amount	Service Provider(s)
<input type="checkbox"/>	___/___/___	___	___	_____.____	
<input type="checkbox"/>	___/___/___	___	___	_____.____	
<input type="checkbox"/>	___/___/___	___	___	_____.____	
<input type="checkbox"/>	___/___/___	___	___	_____.____	

BENEFIT CODES

- M - MEDICAL EXPENSE - OUT OF POCKET
- I - INSURANCE PREMIUM REIMBURSEMENT
- D - DEPENDENT CARE/DAY CARE
- T - TRANSPORTATION

SERVICE CODES

- MD - MEDICAL
- RX - PRESCRIPTION
- OT - OVER-THE-COUNTER
- VI - VISION
- DN - DENTAL
- IP - INSURANCE PREMIUM
- DC - DEPENDENT CARE
- TR - TRANSPORTATION

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Employee Signature (required)

Date / /

0000-0000-0000

REIMBURSEMENT TIPS

Tips to ensure prompt and accurate reimbursements.

- ✦ Incomplete Requests for Reimbursement will be denied.
- ✦ Use only your personalized Request for Reimbursement Form. Please duplicate this Form for future requests. (Non-conforming reimbursement forms will be rejected.) One request form can be used for multiple expenses.
- ✦ When completing the Request for Reimbursement Form enter each different expense on a separate line, identifying the date of service, the benefit type, the service type, and the service provider. Dates of Service always represents the date your services are incurred or rendered.
- ✦ Enter the appropriate benefit and service codes. See front side for a list of codes.
- ✦ Enter the amount requested for each Benefit Code in the Request Amount field for that benefit.
- ✦ You must sign each Request for Reimbursement Form and/or VeriFlex Cover Sheet submitted to FlexSystem.
- ✦ Although reimbursements may be processed prior to expense substantiation (if offered by your employer), all medical expenses must be substantiated by the Participant and verified by FlexSystem. Fax or mail copies of the receipts with your Request for Reimbursement Form to FlexSystem at 608-663-2762 or to TASC, P.O. Box 7308, Madison, WI 53707-7308.
- ✦ For quickest reimbursement, Requests for Reimbursement may be submitted on-line at www.tasconline.com. If submitting on-line, please use the VeriFlex Cover Sheet (available from the web after submission of the Request for Reimbursement) instead of this Form.
- ✦ All Participants are expected to maintain supporting records and documents to validate the expense type and amount. FlexSystem may require additional information or documentation prior to processing a claim.
- ✦ FlexSystem daily processes Requests for Reimbursement, which when received at TASC by noon CST will be processed that business day, with a corresponding payment issued the following business day.
- ✦ Access Participants' account status information on the Internet (at www.tasconline.com), or on FlexSystem's Interactive Voice Response System (at 1-800-422-4661). Participants will need their Client ID, Participant ID and Pin Number to access this information.

REQUEST FOR REIMBURSEMENT

For each request entered, all boxes must be completed. Please check the appropriate box to indicate all attached receipts or substantiating documents.

Rec. Attach	Date of Service (not billing or paid date)			Benefit Code	Service Type Code	Request Amount	Service Provider(s)
	Month	Day	Year				
<input type="radio"/>	1	2	05	03	M	RX	83.18 Walgreens
<input type="radio"/>	1	2	10	03	M	CP	60.00 Dr. Jones
<input type="radio"/>	1	2	11	03	M	DP	116.99 Dr. Carter
<input type="radio"/>	1	2	18	03	D	DC	208.33 Kid Keepers Center

BENEFIT CODES

M - MEDICAL EXPENSE - OUT OF POCKET

D - DEPENDENT CARE/DAY CARE

TASC • 2302 International Lane • Madison, WI 53704-3140 • 1-800-422-4661 • Fax: 608-245-3623 • service@tasconline.com

The information in this communication is confidential and may only be used by the authorized recipient for its intended purpose. Any other use or disclosure is prohibited.