



**FSA Medical Reimbursement Account Claim Form**  
**PO Box 210546 Columbia, S.C. 29221 (800) 951-1012 Fax (803) 772-0140**  
**125claims@benefitcoordinators.com**

*Erskine College*

<b>Name:</b>	Last	First	MI	SS#:
<b>Address:</b>	Street	City	State	Zip
				Daytime Phone Number:

*Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim*

<b>Medical Expense Claim</b>					
Employee / Dependent Name	Relationship	Date of Service	Type of Service	Medical Condition (for OTC Rx Only)	Amount
1.					
2.					
3.					
4.					
5.					
6.					
7.					
				<b>TOTAL AMOUNT REQUESTED</b>	

**EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT**

I certify that the expense for reimbursement from my account was incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual tax return. I agree to notify my Employer if I have reason to believe that any expense(s) for which I have obtained reimbursement is not an Eligible Medical Expense, and also agree on demand to indemnify and reimburse my Employer for any liability it may incur for failure to withhold federal and state income tax or Social Security tax for any reimbursement I receive for an expense which does **not** qualify as an Eligible Expense pursuant to Section 213 of the Internal Revenue Code.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_