SELF INSURED PLANS LLC
14710 Tamiami Trail N, Suite 201
Naples, FL 34110
phone 239.403.7884 • fax 239.403.9028
Hawaii Only: 877-557-4SIP (4747) • Fax: 877-556-4SIP (4747)

FLEXIBLE SPENDING ACCOUNT (FSA)
WITHDRAWAL REQUEST

Employee Instructions

Please read these instructions before completing the FSA Withdrawal Request on the back of this form.

1. Complete all areas of Part 1 "Employee Information." Where applicable, complete Part 2 "Health Care Expenses" and Part 3 "Dependent Care Expenses."
2. For expenses that are payable by any benefit plan, attach a copy of the plan's Explanation of Benefit (EOB) to this form. (Generally, your insurance carrier and any other carrier, e.g., your spouse's or an individual plan, should pay before you request and FSA reimbursement.) Reimbursement amounts should be accumulated and submitted only after they total $25.
3. For expenses not covered under any benefit plan, attach a copy of the paid itemized bill to this form.
4. Read the Employee's Certification for Reimbursement statement, then sign and date the form where indicated.
5. Mail the Withdrawal Request form to the office indicated on the top of this form.

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WITHDRAWAL REQUEST

PART 1. Employee Information

EMPLOYEE NAME (Last, First)						EMPLOYEE DATE OF BIRTH	EMPLOYEE SOCIAL SEC. NO.
EMPLOYEE ADDRESS Number	Street	City	State	Zip Code	EMPLOYEE TELEPHONE NO. ( )		
EMPLOYER NAME	EMPLOYER ADDRESS	PLAN NO.					

DESCRIPTION OF EXPENSES AND WITHDRAWAL AMOUNT REQUEST

Please Place Each Expense on a Separate Line.

PART 2. Health Care Expenses

PATIENT'S FULL NAME	RELATIONSHIP	BIRTHDATE	DATES OF SERVICE FROM	DATES OF SERVICE TO	TYPES OF SERVICE	WITHDRAWAL REQUEST AMOUNT
					SUBTOTAL	$

PART 3. Dependent Care Expenses

DEPENDENT'S FULL NAME	DATES OF SERVICE FROM	DATES OF SERVICE TO	TYPES OF SERVICE	WITHDRAWAL REQUEST AMOUNT
			SUBTOTAL	$
			Total Request For Withdrawal	$

TOTAL MUST BE AT LEAST $25.00

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible, for reimbursement under my FSA. I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filling my (our) individual income tax return.

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

Employee Signature _____ Date _____