



3035 Lakeland Hills Boulevard • Lakeland, FL 33805-2225 • 800.226.3155

Flex Debit Card Swipe Validation

To: Flexible Spending Account Department # of pages (including cover sheet): _____

Fax: 888.285.5123 Date: _____ Time: _____

Please complete this form and fax it to us along with your receipt(s)

Employee Name: _____ Employer: _____

SS #: _____ Phone #: _____ Date _____

Date of Debit Card Swipe	Provider Name	Expense Description	Person for Whom Expense Incurred	Amount
Total Medical Care Claim Amount				

I certify that these expenses for which reimbursement is claimed from my healthcare reimbursement account have been incurred by me and/or my eligible dependents during the applicable plan year and are not payable by any other plan. I further declare that I have not and will not deduct these expenses on my federal income tax returns and my employer will provide this information on request of the IRS to the IRS.

Employee Signature Date Submitted

★ Don't forget you have 24/7 access to your Flexible Spending Accounts at www.online-enrollment.com/FL1st ★

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