



# Flexible Spending Plan Reimbursement Voucher

\*Please read the back of this form for instructions on how to complete this voucher\*

**EMPLOYER / GROUP NAME**

**YOUR NAME**

**S.S. NUMBER (Last 4 Digits)**

**YOUR ADDRESS**

**CITY**

**STATE**

**ZIP**

Please check this box if this is a change of address.

To ensure you receive notification of claim(s) status, please update your Email address in the Benefits Portal at [www.ThePreferredGroup.com](http://www.ThePreferredGroup.com).

Unreimbursed Medical Expenses <i>Receipts must include description of service, date of service, and amount.</i>			Dependent/Child Care Expenses <i>Submit receipt including date of service, amount, and SS# or Tax ID# OR have provider fill out and sign below</i>		
Nature of Service	Date(s)	Amount	Name of Day Care Provider	Signature of Provider	SSN / Tax ID
1		\$			
2		\$	Name of Dependent	Age	Disabled
3		\$			Yes <input type="checkbox"/> No <input type="checkbox"/>
4		\$			Yes <input type="checkbox"/> No <input type="checkbox"/>
5		\$			Yes <input type="checkbox"/> No <input type="checkbox"/>
6		\$	Description of Service	Date(s)	Amount
7		\$	1		
8		\$	2		\$
9		\$	3		\$
10		\$	4		\$
<b>TOTAL</b>		<b>\$</b>	<b>TOTAL</b>		<b>\$</b>

**READ CAREFULLY AND SIGN**

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

**SIGNATURE**

*Date*

Send completed vouchers to:

Preferred Group Plans, Inc.  
P.O. Box 15136  
Albany, NY 12212-5136  
(518) 591-4960 (866) 989-8995  
Fax: (518) 641-0325  
[www.ThePreferredGroup.com](http://www.ThePreferredGroup.com)

Minimum Request: \$25.00

++SEE REVERSE FOR DETAILS