Flex Benefits Card Receipt Coversheet

If emailing, please email to: flex@goigoe.com. If faxing, please fax to: (858) 430-5825

Use of this form will not result in a reimbursement from your Flexible Benefit Account.

Use this form only for proof of purchase with your Flex Benefits Card issued through your Employer.

INSTRUCTIONS

1. Complete all applicable sections of this form including your signature and the current date.
2. Attach all Itemized Bills, Explanations of Benefits, Statements of Service or itemized receipts for your Flex Benefits Card expenses. Keep in mind:
   - Canceled checks and charge card receipts or balance due statements without itemization are not satisfactory receipts as they do not indicate necessary information to determine eligibility or an expense.
   - Documentation for health care expenses must show original date of service, name of doctor or provider of services, description of the item or expense and the amount paid.
   - Prescription receipts must show the date the prescription was filled, name of the doctor, name of the patient, name of medication and amount paid.
3. Flex Benefits Card receipts received Monday through Friday before 5:00 PT will be reviewed within 1 business day.
4. Always keep copies of receipts for your records

ABOUT YOU

Employer Name	Number of Pages

Participant's Name	First 5 digits of Participant's Social Security Number
E-mail Address **(Required)** ☐ **Please check if this is a change in email address**	Daytime Phone Number

MEDICAL CARE EXPENSES INCURRED (for participant and all tax dependents)

Transaction Date	Merchant Name	Description of Expense	For Whom (relationship to participant)	Amount
/ /				$
/ /				
/ /				

AUTHORIZATION: *REQUIRED (PLEASE SIGN AND DATE)

I certify that all expenses on this form and the receipts attached to it were incurred during the Plan Year while I was covered under the Flexible Benefit Plan with respect to such expenses and, that these expenses have not been or are not being reimbursed under any other benefit plan. I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to this request. I also understand that each expense for which the benefits card was used must be a proper expense under the Plan. If not, I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that **NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE.**

PARTICIPANT'S SIGNATURE: ______________________________ DATE: ______________