Clear Form

Flexible Benefits Card Receipt Substantiation Coversheet

Use this form ONLY for items and services that you paid for using your Flexible Benefits Card. Completion of this form is only required if you have received an email indicating that additional documentation is needed to determine the eligibility of your expense.

INSTRUCTIONS

1. **Complete** all applicable sections of this form. Remember to sign and date the bottom of this form.
2. **Attach** all supporting documentation.
3. **Submit** this completed form and supporting documentation to Igoe Administrative Services for review via:
   - Secure Upload through your personal account at www.goigoe.com
   - Email to flex@goigoe.com
   - Fax to 858-430-5825
   - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
4. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Click For Additional Tips

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Last 4 Digits of the Flexible Benefits Card Used	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Medical Care Expenses Incurred (for participant and all federal tax dependents)

Clear Section B

Service Date (mm/dd/yy)	Name of Doctor / Provider of Services	Description of Expense	Person Incurring Expense Name, Age, Relationship	Net Amount
				$
				$
				$
			Total Medical Care	$ 0.00

Section C: Authorization *REQUIRED (PLEASE SIGN AND DATE)

As a participant in the Plan, I certify that all above expenses were incurred during the Plan Year while I was covered under the Flexible Benefit Plan and that the 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 further acknowledge that each expense for which payment or reimbursement is requested must be a proper expense under the Plan. If not, I understand that 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 REIMBURSMENT IS MADE. Having agreed to all of the proceeding statements, I authorize the Flexible Benefit Plan Account/s in my name to be reduced by the eligible amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

Signature: Ready To Sign? Click To Print ***Date:*** _____

IGOE ADMINISTRATIVE SERVICES

rev. 121003a