CORESOURCE
A Trustmark Company

COREFLEX
FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST FORM

Phone: 1-877-267-3359 SEE REVERSE SIDE FOR INSTRUCTIONS FAX: 501-221-9074

A. EMPLOYEE INFORMATION

Name	Social Security Number	Employer Name	
Address	City	State	Zip

B. HEALTH CARE SPENDING ACCOUNT

Dates of Service	Provider of Service	Person for Whom Service Provided	Relationship to You	Amount
				$
TOTAL AMOUNT REQUESTED				$

C. DEPENDENT CARE SPENDING ACCOUNT

Dates of Service	Provider of Service	Caregiver's SSN or ID#	Dependent's Full Name	Dependent's Date of Birth	Amount
					$
TOTAL AMOUNT REQUESTED					$

D. CERTIFICATION

I certify that the following is true:

1. The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement. (See reverse side for a description of eligible expenses.)
2. The expenses listed above are not eligible for reimbursement by any insurance plan.
3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
4. The appropriate bills, receipts, Explanation of Benefit Statements or documentation for day care expenses are attached. **Please keep copies of supporting documentation for your records Documents will not be returned.**
5. For Over-the-Counter medications to be eligible expenses under the plan, they must be for the diagnosis, prevention or treatment of a specific medical condition and not just for the overall good health of the participant.

Employee Signature	Date

Please return this form to:

CoreSource
Attn: Flexible Spending Department
P. O. Box 8215
Little Rock, AR 72221
e-mail address: coreflex@coresource.com