First Concord Benefits Group

www.myflexonline.com

FAX TO:	First Concord Benefits Group
	402- 423 - 4549
# Pages: ______	(NO COVER PAGE REQUIRED)
CONTACT NUMBER	TEL:

MAIL TO: P.O. Box 67220
Lincoln, NE 68506

Phone: 402-423-4454

Section 125 Claim for Reimbursement

CLAIM YEAR: ____ Current
____ Last

Employer:	
Employee Name:	Social Security Number:

Dependent Care Expenses

Name, Address of Provider of Services	Dates Expense Incurred	Amount
	TOTAL	

NOTE: The Day Care expense is an eligible expense only if it enables you and your spouse to be able to work. No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or step-child and under the age of 19.

Unreimbursed Healthcare Expenses

Name, Address of Provider of Services	Dates Expense Incurred	Amount
	TOTAL	

Personally (employee) Owned Insurance Expense

Name of Company and Type of Insurance	Date Premium Expense Incurred	Amount
	TOTAL	

Read Carefully

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, and city income tax on amounts paid from the Plan which related to such expense.

**DON'T FORGET TO ATTACH DOCUMENTATION.

______________________________ ______________
Employee Signature Date

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