

**Flexible Spending Account  
Flex Debit Card Receipt Submission Form  
(This form is to be used when you are asked to submit a receipt)**

Please complete all Personal Information (print clearly or type)

**Personal Information**

<b>Employee</b>	
<b>Social Security #</b>	
<b>Company/Employer</b>	
<b>Daytime Telephone #</b>	
<b>Date of Request</b>	
<b>Email Address</b>	

Date(s) of Service	Service Provider or Merchant	Amount Requested
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$
6.		\$
<b>Total Amount Requested</b>		<b>\$</b>

You must sign and date this form – attach all receipts relating to this claim in order for us to process this claim. You may **fax** toll-free to 1-877-4 FAX 24/7 [1-877-432-9247] or mail to:

Stanley Benefit Services, P. O. Box 29329, Greensboro, NC 27429

*I, the undersigned, hereby certify that the above expenses have not been previously reimbursed from my Flexible Spending Account, nor have they been or are reimbursable from any other source. I hereby authorize Stanley Benefit Services to obtain the necessary information from all physicians, hospitals, daycare providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Flexible Benefit Plan established by my Employer.*

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

Stanley Benefits, Inc. ✦ P. O. Box 29329 ✦ Greensboro, NC 27429-9329

Toll-Free Telephone: (877)SBS-FLEX [877-727-3539]

Toll-Free Fax: (877)4-FAX-24-7 [877-432-9247]