BENEFIT ADMINISTRATORS, INC.
1250 Tower Lane
Erie, PA 16505

Phone: (814) 454-0167
Fax: (814) 461-9402

FLEXIBLE SPENDING PLAN
CLAIM SUPPORTING STATEMENT

EMPLOYER'S NAME:	
EMPLOYEE NAME:	**SSN:**
ADDRESS:	
EMAIL ADDRESS:	

Enclosed are copies of all supporting documents, receipts, vouchers, etc., to document the expenses listed below. The original receipts have been retained for my records.

Medical/Dental/Vision Reimbursements	$
Dependent Care Reimbursements (day care)	$

Any unused amounts in my account will be forfeited at the end of the plan year. I certify that I have not requested reimbursement under this plan or from any other source for these charges.

I CERTIFY that the above information is correct and complete.

Signature Date

PLEASE KEEP A COPY OF THIS CLAIM FORM AND SUBMITTED RECEIPTS FOR YOUR RECORDS

Please email: Email: hdh.hb.FSA@hubinternational.com **with any questions**