INSURANCE MANAGEMENT SERVICES

P.O. Box 15688 • Amarillo, TX 79105

FLEXIBLE SPENDING ACCOUNT (FSA) WITHDRAWAL REQUEST

Please fax flex claims to (806) 322-3142
Or email to Flex.Admin@imsm.net

• PART 1. Employee Information

EMPLOYEE NAME (LAST/ FIRST)			EMPLOYEE DATE OF BIRTH	
EMPLOYEE ADDRESS	City	State	Zip	EMPLOYEE PHONE NUMBER
EMPLOYER NAME	EMPLOYER ADDRESS			CASE # CERT # DIVISION

DESCRIPTION OF EXPENSES AND WITHDRAWAL AMOUNT REQUEST

• PART 2. Health Care Expenses (Please place each expense on a separate line)

PATIENT(S) FULL NAME	RELATIONSHIP	BIRTHDATE	DATES FROM	TO	TYPES OF SERVICE	WITHDRAWAL REQUEST AMOUNT

SUBTOTAL _____

• PART 3. Dependent Child Care Expenses

DEPENDENT(S) FULL NAME	DATES FROM	TO	TYPES OF SERVICE	WITHDRAWAL REQUEST AMOUNT

SUBTOTAL _____

Total Request For Withdrawal _____

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable by law.

Employee Signature: _____ Date: _____