



All claims must be in our office **5 working days** prior to your scheduled check run.

Lifestyle Spending Account Claim Form

PARTICIPANT PROFILE

PARTICIPANT NAME: _____ SOCIAL SECURITY #: _____

REIMBURSEMENT REQUEST

Please complete the request below and attach a copy of a Receipt or an Itemized Statement with service and payment dates to this form and retain copies for your records. *Please be aware that eligible expenses can vary for each employer group.*

AMOUNT REQUESTED	DATES OF SERVICE	
\$	FROM	TO
\$	FROM	TO
\$	FROM	TO
\$	FROM	TO

\$ _____ TOTAL AMOUNT REQUESTED

AUTHORIZATION

I certify that this information is correct, complete and meets all requirements for eligible expenses under my employer's Lifestyle Spending Account.

PARTICIPANT SIGNATURE _____ DATE _____
COMPANY NAME _____ GROUP NUMBER _____

CLAIMS ADDRESS

PO Box 1349 WAKE FOREST, NC 27588
ATTN: CONSUMER ACCOUNTS DEPARTMENT
PHONE: 919-877-9933 EXT 5052 FAX:919-562-0021