

PriorityFSASM Flexible Spending Account (FSA)



WITHDRAWAL REQUEST

Attention: ASO Flex MS 2260
1231 East Beltline NE • Grand Rapids, MI 49525-4501 • Fax: 616 942-0631

SECTION 1 - EMPLOYEE INFORMATION		
EMPLOYEE NAME (Last & First)	EMPLOYEE DATE OF BIRTH	EMPLOYEE SOC. SEC. NO.
EMPLOYEE ADDRESS Number Street City State Zip	EMPLOYEE TELEPHONE NO.	
EMPLOYER NAME	CONTRACT NO.	GROUP NO.

SECTION 2 - MEDICAL CARE EXPENSES (Supporting Documentation Must Be Attached)						
PATIENT'S FULL NAME	RELATIONSHIP TO EMPLOYEE	BIRTHDATE	DATES OF SERVICE		TYPE OF SERVICE	WITHDRAWAL REQUEST AMOUNT
			FROM	TO		
TOTAL						\$

For expenses that are payable under any health plan, attach a copy of the Explanation of Benefits (EOB) to this form. Generally, your health/dental plan or any other carrier should make payment before you request an FSA reimbursement.

SECTION 3 - DEPENDENT CARE EXPENSES (Supporting Documentation Must Be Attached)						
DEPENDENT CARE PROVIDER INFORMATION	NAME	ADDRESS			TAX I.D. OR SSN	
DEPENDENT'S FULL NAME	RELATIONSHIP TO EMPLOYEE	BIRTHDATE	DATES OF SERVICE		WITHDRAWAL REQUEST AMOUNT	
			FROM	TO		
TOTAL						\$

SECTION 4 - EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT
<p>I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents) were not reimbursed by or are reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under 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.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Any person who knowingly files a statement of claim containing false or misleading information may be guilty of a criminal act punishable under law.</p> </div> <p>SIGNATURE REQUIRED</p> <p>Employee Signature _____ Date _____</p>