

WITHDRAWAL REQUEST - FOR USE WITH AN HSA HEALTH PLAN

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 - 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; text-align: center;"> <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>