STERLING ADMINISTRATION

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1.888.410.7361
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FLEXIBLE SPENDING ACCOUNT DISBURSEMENT FORM (DO NOT USE FOR HSA OR HRA DISBURSEMENTS)

EMPLOYEE INFORMATION *(PLEASE PRINT)*

Name SSN # Email Phone Employer

Employee Address City State Zip

Please change the address on my account to the above: ☐ For this disbursement only ☐ Permanently on my account

☐ Please reimburse me ☐ Please pay my provider (attach provider invoice)

IMPORTANT: For all claims listed, you must attach supporting documentation (such as receipts) that include: Provider's Name, Provider's Address, Amount Billed, Service Provided, and Actual Dates of Service. (Note that dates of payment are not sufficient.)

MEDICAL EXPENSES

PERSONS FOR WHOM EXPENSE WAS INCURRED	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	DESCRIPTION OF EXPENSE	AMOUNT
			TOTAL MEDICAL EXPENSES	

DEPENDENT CARE / DAYCARE EXPENSES

(Attach supporting documentation)

DEPENDENT INFORMATION (NAME, AGE, RELATIONSHIP)	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	PROVIDER'S TAX ID OR SSN & DESCRIPTION OF EXPENSE	AMOUNT
			TOTAL DEPENDENT CARE/DAYCARE EXPENSES	

READ CAREFULLY

I certify that I am a participant in the Flexible Spending Account (FSA) Plan and confirm that these expenses, for which reimbursement is requested, have been incurred during the Plan Year while I was covered under the FSA Plan. These expenses have not been reimbursed by any other benefit plan. I understand that I am responsible for the validity of this request and all information pertaining to it. I further understand that I am liable for all related Federal, State or City taxes for any invalid request submitted by me and I will not claim credit for reimbursed expenses on my individual tax return.

Participant Signature Date

Mail To: Sterling, P.O. Box 71107, Oakland, CA 94612
Email To: benefits@sterlingadministration.com | **Fax To:** 888-410-7361

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