



**Boys Hope Girls Hope**

**REIMBURSEMENT REQUEST - FLEXIBLE BENEFITS ACCOUNT  
MEDICAL CARE**

1. Complete Parts A & B in full
2. Attach a copy of the Explanation of Benefits (E.O.B.)
3. Attach any prescription receipts

**Submit Claims to: Benefits Manager, National  
12120 Bridgeton Square Drive  
Bridgeton, Missouri 63040**

<b>PART A FAILURE TO ANSWER ALL QUESTIONS MAY DELAY PAYMENT</b>			
EMPLOYEE NAME (First Name, Middle, Last Name)			
STREET ADDRESS	CITY	STATE	ZIP CODE
<b>PART B REIMBURSEMENT REQUEST</b>			
1. Total Health Expenses Incurred	\$		
2. Amount paid/payable by your employer's plan and/or other insurance	\$		
3. Balance to be considered under the Flexible Benefits Account	\$		

**EMPLOYEE CERTIFICATIONS**

- I am covered under an insurance plan (group or individual) or an employer sponsored employee benefit plan. My explanation of benefits (E.O.B.) are enclosed.
- I have no coverage for the attached expense(s).

I certify that the attached charges are eligible health care expenses under the Internal Revenue Code (IRC) and that these charges have been incurred and I have not been reimbursed by any other source for these charges. I also certify that they will not be claimed as a deduction on my personal income tax.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**CLAIMS MUST BE RECEIVED BY THE 5TH FOR PAYMENT  
ON THE 15TH OF EACH MONTH**

