CPI

Flexible Spending Account

Medical Expense Claim Form

Employer: _____ ***Plan Year:*** _____

Participant: _____ ***Last Four of SSN:*** ***XXX-XX-*** _____

Address: _____

City, State, Zip Code: _____

Phone: _____ ***Email:*** _____

List Unreimbursed Medical Expenses by Classification	***Amount $***
Prescriptions	
Doctor/Hospital Co-Pays and Deductibles	
Dental/Vision/Hearing Services, Equipment and/or Supplies	
Medical Procedures/Services,Therapy, Labs and Tests	
Over-the-Counter Medicine (attach copy of prescription for each)	
Other:	

- ***All claims require copies of bills/statements/receipts that include the date of service****
- ***Canceled checks, bank statements, and credit card receipts are not adequate. An itemized receipt or statement must be provided in order to substantiate a claim.***
- ***Expenses must be incurred during the plan year noted at the top of this form. For terminated employees, claims must additionally be incurred prior to the date of termination of employment.***
- ***Reimbursements are issued weekly. Monday, checks will be mailed and Direct deposits will occur, for claims approved prior to Wednesday at 3pm (Central Time) of the preceding week.***

**The date of service is the date that the participant went to see the health care provider or dentist. This is not the date a bill was received or paid.*

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's cafeteria plan. I have not been and will not be reimbursed for these expenses from any other source, including but not limited to, an insurance plan, this plan, or other programs that may be offered by my or my spouse's employer. I understand these expenses may no longer be claimed as deductions for income tax purposes, since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge that I am solely liable for any taxes or penalties on ineligible expenses submitted through the medical flexible spending account. I am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses and, if applicable, reaffirm the authorization provided to Cobra Professionals, Inc. to issue reimbursement via direct deposit to my bank account on file.

Participant Signature: _____ ***Date:*** _____

Completed claim forms and copies of receipts may be faxed to (225) 706-0280 or scanned and emailed to cpisupport@mycpiteam.com. Please retain originals for your records.