

The George Washington University
 Plan Year: 1.01.08 - 12.31.08
 Flexible Spending Account Request for Reimbursement

GWU



Employee First Name	Employee Last Name
Employee ID No.	Daytime Phone #
Home Address <input type="checkbox"/> Check here if new address	
E-Mail Address <input type="checkbox"/> Check here if new address	

Unreimbursed Medical Expenses		
Date(s) of Service	Physician or Other Provider	Expense Amount
Total Amount Requested		

Dependent Care Expenses		
Date(s) of Service	Provider	Expense Amount
Total Amount Requested		

Dependent Care Provider Signature (If no receipt is provided)	
I certify that the above listed Dependent Care charges have been incurred.	
Provider Signature	Date

Participant Statement	
I certify that the expenses listed above have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of knowledge all expenses listed above are eligible for reimbursement under the plan. I certify that any prescription drug expenses submitted are for medical care and not cosmetic purposes (e.g., Propecia for male pattern baldness, Retin-A for smoothing wrinkles, etc.). I understand that I am responsible for the accuracy of the information related to this request. I have not and will not seek to be reimbursed through any other health plan coverage and/or dependent care assistance plan for any of the expenses listed above. I further declare I will not deduct any of the reimbursed medical expenses listed above from my federal, state or local tax returns.	
Participant signature	Date

Please email, mail or fax claim forms to: claims@hfsbenefits.com Claims Department, HFS Benefits 164 Lakefront Drive, Hunt Valley, MD 21030 Phone: 410.771.1331 / Toll Free: 888.460.8005 Fax: 410.771.5533 / Toll Free 888.510.4218 ****PLEASE DO NOT MAIL ORIGINALS****	Have you visited www.hfsbenefits.com ? Go to www.hfsbenefits.com Click on the "HFS Account Login" button Enter your User Name (Employee ID Number) Enter your Password: 1177
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