DEBIT CARD ACTIVITY RECEIPT DOCUMENTATION FORM

Instructions:
*Complete all applicable spaces on the form.
*Attach all debit card receipts including a photocopy of the doctor's prescription for any over-the-counter medicines or drugs and forward to Tucker Administrators, Inc.
*All documentation must include original dates of service.
*Keep a copy for your records

DEBIT CARD ACTIVITY ONLY

Employer_____ Group / Division Number_____ Date_____

Employee Name _____ SSN _____-_____-_____

Home Address_____

Email Address:_____

Medical Related Expense for: Patient Name _____ SSN _____-_____-_____

Medical Related Expense Amount: $_____.____ Benny® Card Number: _____

If faxed please provide a day time phone number for possible questions about your claim:_____

To the best of my knowledge and belief, my statements in the Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Compensation Account be reduced by the amount requested.

Employee Signature_____ **Date**_____

3800 Arco Corporate Dr. Ste. 450, Charlotte, NC 28273 Ph: 704-525-9666 Fax: 704-525-9534