



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