TRANSACTION SUBSTANTIATION FORM

BENEFITS CARD - FLEXIBLE BENEFIT PLAN

Employer's Name ______________________________

Employee's Name ______________________________ SS# ____________________

Date of Transaction	Name of Merchant	Type of Eligible Expense (If OTC product, please write explanation of what product is)	Amount of Expense

I, the participant, hereby certify that each expense was incurred on the date and for the reason noted. The expense(s) listed was incurred for medical care, not general health purposes, and excludes cosmetic and/or toiletry expenses. I, the participant, certify that I have not been reimbursed for the expense(s) noted above and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted above has been paid for by use of my Benefits Card.

Attached are itemized receipts or bills to substantiate my Benefits Card transaction. I understand that I may NOT use this form to seek reimbursement for items paid out-of-pocket; I may do so by filing a Claim Form, found at www.flex-admin.com.

Please Be Aware: A letter of medical necessity must be attached if the drug is considered a "dual purpose" item.

I authorize the service provider to release any information requested by the Plan Administrator in connection with this transaction.

Employee's Signature ______________________________ Date ____________

Mail This Form To:

Flexible Benefit Administrators, Inc.
Attn: Benefits Card Department
P.O. Box 8188, Virginia Beach, VA, 23450

Or

Fax This Form To: (Please include cover sheet)

Flexible Benefit Administrators, Inc.
Attn: Benefits Card Department
Fax Number: 757-431-1155

This form can also be scanned and emailed to benefitscard@flex-admin.com

PLEASE DO NOT mail your completed form if you fax it.
PLEASE KEEP a copy of all completed forms and receipts for your records
PLEASE NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address