

**FLEXIBLE REIMBURSEMENT
ACCOUNT CLAIM FORM**

RETURN FORM TO:
VPC GROUP
500 N. Birdneck Road
Virginia Beach, VA 23451
PHONE: (757) 422-8880
FAX: (757) 425-8666

**Include Receipts with
this Form**

Employer's Name: Door & Glass Services

[] check if new address

Section A - Employee Information (PLEASE PRINT)			
EMPLOYEE'S LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY, STATE, ZIP CODE	
			DAYTIME PHONE NUMBER

Section B - ACH Direct Deposit (PLEASE PRINT AND VERIFY ACCURACY)	
<input type="checkbox"/> CHECKING ACCOUNT <input type="checkbox"/> SAVINGS ACCOUNT <input type="checkbox"/> BANK INFORMATION ON FILE	Please attach voided check or deposit slip to this form or ACH cannot be processed
BANK ROUTING NUMBER	BANK ACCOUNT NUMBER
EMAIL ADDRESS FOR STATEMENT OF ACCOUNT FOR ACH	FAX NUMBER FOR STATEMENT OF ACCOUNT FOR ACH

If no ACH Information is indicated, a check will be mailed to address listed in Section A. Effective 4/1/04, if a check is issued there will be a \$1.00 processing fee deducted from your reimbursement account. When using ACH Direct Deposit there will be no fee imposed. ACH Direct Deposit can take up to (2) business days to reach account from the date reimbursement is received and processed.

Section C - Medical Expense Reimbursement (PLEASE PRINT- LIST SEPARATELY)				
Dates of Service/Purchase	Name of Person Receiving Service	Name of Provider of Service	Type of Service/Supply Provided	Expenses Incurred
				\$
				\$
				\$
				\$
TOTAL				\$

Section D - Dependent Care Reimbursement (PLEASE PRINT - LIST SEPARATELY)				
Dates of Service	Full Name of Person(s) Receiving Service	Relationship to Employee	Age(s)	Expenses Incurred
				\$
				\$
				\$
TOTAL				\$

Section E - Provider Information (for Dependent/Day Care only)				
For expenses to be eligible this section must be completed and signed by the Provider of dependent/day care services.		Total expense incurred for services rendered to the individual(s) on the date(s) specified in Section C.	TOTAL	\$
PROVIDER NAME	TAX I.D. NUMBER	PROVIDER SIGNATURE	DATE	

Section F - Employee Signature	
I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. These expenses have not been previously submitted for reimbursement to this or any other flexible reimbursement account.	
EMPLOYEE SIGNATURE	DATE