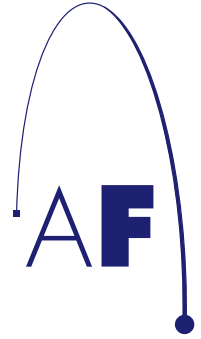


**AMERIFLEX**

TRANSACTION SUBSTANTIATION REQUEST



**Employer:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employee Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please check box if the above information reflects a change of address:

Date of Expense \_\_\_\_\_

Type of Expense:  Prescription  CoPay  Vision  Dental  Other \_\_\_\_\_

Proof of Expense Attached?  Yes  No (see statement below)

Is this a recurring expense?  Yes  No (If "Yes", you do not need to substantiate this expense moving forward)

If you are unable to provide a receipt or if the expense is ineligible, please attach a check or money order made out to AmeriFlex to reimburse your account. Failure to provide proper documentation for an eligible expense or to reimburse your plan for an ineligible expense can result in the termination of your AmeriFlex Convenience Card® and your plan.

"To the best of my knowledge and belief, the above statements are complete and true. I certify all of the following: Either I or my eligible dependent has received the services described above on the dates indicated; the expense(s) qualify as valid Medical expenses under my plan; if the expense is for my spouse/dependent, that person is my spouse or dependent as defined by my plan; I have not been and will not be reimbursed by any other source for this expense."

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_