SECTION 125 FLEXIBLE BENEFIT PLAN
EXPENSE REIMBURSEMENT VOUCHER

Name of Employer		Daytime Phone ( )
Name of Employee (Last, First, M.I.)		Social Security #
Address	City & State	Zip Code

[ ] CHECK HERE IF THIS IS A NEW ADDRESS

Please complete the worksheet below by indicating the date your expense was incurred, the type of expense being reimbursed, the name of person for whom expense was incurred, and the amount of the expense. Only include expenses for you or your dependents and expenses for which you have not previously filed for reimbursement.

Date of Expense	Type of Expense Medical	 Dep. Care	Name of Person for Whom Expense Was Incurred	Amount of Expense Medical	 Dep. Care
TOTAL					

MEDICAL EXPENSES: For each medical expense listed above, attach the statement you received when the service was provided or the insurance company statement of benefits. For expenses that are or may be covered under a health insurance plan, submit your bills to the insurance company(ies) and then submit the insurance company statement of benefits showing the amount of expenses not covered by insurance with this form. For prescription drugs, attach the original pharmacy statement - a cash register tape is not acceptable. You should keep a copy of each statement, bill, or insurance company statement of benefits submitted with form for your records.

DEPENDENT DAY CARE EXPENSES: For each dependent day care expense listed above, attach a completed Dependent Day Care Provider Acknowledgement form which has been signed by your dependent day care provider.

When a fax is received we reserve the right to request the original expense documentation at anytime. In some instances, we may not reimburse an expense until the requested documentation is received. Please do not send the originals unless requested.

I HEREBY CERTIFY that the expense(s) shown above has not been, and will not be paid or reimbursed by an insurance company, or from any other source. I understand that any amounts not used for qualified expenses by the end of the plan year will be forfeited to my employer.

Date Signed

Signature of Employee

NOTE: MEDICAL EXPENSES WHICH HAVE BEEN REIMBURSED UNDER THIS PLAN ARE NOT DEDUCTIBLE BY THE EMPLOYEE FOR FEDERAL INCOME TAX PURPOSES. IN ADDITION, DEPENDENT DAY CARE EXPENSES REIMBURSED UNDER THIS PLAN MAY NOT BE USED FOR DEPENDENT DAY CARE TAX CREDIT PURPOSES BY THE EMPLOYEE.

FAX NUMBER: 1-800-543-3539
MAILING ADDRESS: AMERICAN FIDELITY ASSURANCE COMPANY
FLEX ACCOUNT ADMINISTRATION
P.O. BOX 25510
OKLAHOMA CITY OK 73125