DEBIT CARD SUBSTANTIATION CLAIM FORM

(This claim form is to be used for FSA and/or HRA Debit Card Substantiation ONLY)

Employee Name: _____ Employer Name: _____

Address: _____ Social Security Number: _____

City/St/Zip: _____ Phone #: _____

Take Care Debit Card Substantiation

Date of Take Care Debit Card Charge	Expense Description	Amount of Charge	NQE Amount	Total Amount to be Substantiated
Attach appropriate receipt(s) and/or itemized bills/EOBs and submit with claim form.		**Total Substantiation Expenses**		**$**

Read Carefully: When filing your claim, you must attach copies of the receipts. The receipt/itemized bill/EOB must include the service provider's name and the date and type of service for each expense. Canceled checks, credit card slips, or statements of balance due are not acceptable. If you fax your claim forms and receipts, please do not follow up with hardcopy. Always retain a copy of all forms and receipts. You may make copies of this form for your future use.

DO NOT INCLUDE OUT-OF-POCKET EXPENSES REQUIRING REIMBURSEMENT ALONG WITH THIS CLAIM FORM. PLEASE USE THE FSA OR HRA REIMBURSEMENT CLAIM FORM FOR THOSE EXPENSES.

The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan and/or Health Reimbursement Arrangement and that the medical expenses have not been nor will be reimbursable under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature Date

CORPORATE PLANNING NETWORK, INC.
P. O. Box 1748 / Cordova, TN 38088
1-800-737-0125 / 901-756-8244 / 901-756-8322 Fax / claims@cpnflex.com E-mail