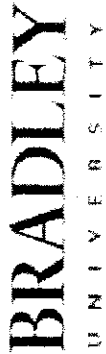


**FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT CLAIM FORM**



Return Completed Form to:

FLEXIBLE BENEFITS
HCH Administration, Inc.
209 W. R.B. Garrett Ave
Peoria, IL 61605-2502
Fax # 309-673-3686

309-673-7330 OR 1-800-322-1516 EXT. 5008

E-Mail Address flex@hchadmin.com

IMPORTANT!!! E-mail address not secure - please use discretion when sending protected health information through the Internet

PART A-----CLAIMANT DATA-----

NAME OF EMPLOYEE _____

NEW ADDRESS NO YES

EMPLOYEE'S ADDRESS _____

CITY _____

STATE _____ ZIP _____

PART B-----EXPENSES TO BE REIMBURSED-----

Claims filed within the 2 ½ month grace period will be paid in the order in which they are approved, using any unused amounts from the prior plan year first. Once paid, no claim will be reprocessed.

INDIVIDUAL(S) WHO QUALIFY AS AN IRS DEPENDENT UNDER IRC CODE 152 FOR WHOM DOCUMENTATION IS ATTACHED	BIRTH DATE	RELATIONSHIP TO EMPLOYEE	DESCRIPTION OF EXPENSE	DATE INCURRED	AMOUNT ELIGIBLE FOR PAYMENT (YOUR OUT OF POCKET AMOUNT)	COVERED UNDER A MEDICAL PLAN?
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No
						Yes (need EOB) No

PART C-----EMPLOYEE'S STATEMENT-----

I hereby certify that the information contained in Part B of this Reimbursement Claim is true and correct, that each item of expense is eligible for reimbursement under the Plan. I certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits. I attest that none of the submitted claims are cosmetic in nature. I understand that I am responsible for providing proof to support my claim for an unreimbursed expense. I also understand that if I am reimbursed for an expense that is determined to be ineligible, the amount of the expense will be considered taxable income to me, and I may also be subject to interest and penalties by the IRS and will be responsible for reimbursing the plan up to the amount of error. I further understand that the claims administrator is relying on my representations as to the eligibility of the expenses for reimbursement, and I acknowledge that neither Bradley University nor HCH Administration, Inc. are responsible for verifying that my representations are correct. I further understand that no tax deductions or credits are permitted for which reimbursement is made.

Date _____

Signature of Employee _____