BRETHREN FLEXCARE
a not-for-profit ministry of Church of the Brethren Benefit Trust, Inc.
1505 Dundee Avenue, Elgin, IL 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
www.brethrenbenefittrust.org

Account Withdrawal Request

Submit to: BBT
ATTN: Insurance Services
1505 Dundee Avenue, Elgin, IL 60120

Participant Instructions

Please read these instructions before completing the FlexCare account withdrawal request on the back of this form.

1. Complete all areas of Part I, "Participant Information." Where applicable, complete Part III, "Medical Reimbursement," and Part IV, "Dependent Care Reimbursement," on the other side of this form.
2. For expenses submitted to, but not paid by, a benefit plan, you may request reimbursement from your medical reimbursement account by completing the Account Withdrawal Request Form. For expenses that have been submitted to any benefit plan, attach a copy of the plan's Explanation of Benefits (EOB) to this form. (Generally, all insurance carriers, e.g., your spouse's or an individual plan, should pay before you request reimbursement from your FlexCare account.) Reimbursement amounts should be accumulated and submitted only after they total $50.
3. For expenses not covered under any benefit plan, attach to this form a copy of the bill or other documentation as proof of your incurred expense.
4. Read Part II, "Participant's Certification for Reimbursement"; then sign and date the form where indicated.

Part I – Participant Information

(Please print)

Name _____

Home Address _____

_____ SSN _____

Home Telephone Number (include area code) _____ Date of Birth _____

Employer Name _____ Address _____

Part II – Participant's Certification for Reimbursement

I certify that the expenses for reimbursement requested from my FlexCare account were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FlexCare account. I (we) will not use the expenses reimbursed through the FlexCare program as deductions or credits when filing my (our) individual income tax return.

Participant signature _____ Date _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Part III – Medical Reimbursement

Patient's Full Name	Relationship	Birthdate	Dates of Service		Types of Service	Withdrawal Request Amount
			From	To		
					Subtotal	$

Part IV – Dependent Care Reimbursement

Dependent's Full Name	Relationship	Birthdate	Dates of Service		Types of Service	Withdrawal Request Amount
			From	To		
					Subtotal	$
					TOTAL REQUEST FOR WITHDRAWAL **Total must be at least $50**	$