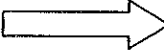


MEDICAL EXPENSES REIMBURSEMENT FORM

Meredith College

1. EMPLOYEE INFORMATION	
<input type="checkbox"/> <i>Check box if new address</i>	Name _____ Employee ID Number _____
	Home Address _____ City _____
	State _____ Zip Code _____
Sign Here <i>Employee Signature Required</i> 	Employee Certification I certify that I have incurred expenses in the amount shown below and the attached receipts are for those qualified expenses for reimbursement under the provisions of my employer's Benefit Choice Plan. Such expenses have not been previously reimbursed under this or any other plan and will not be submitted for reimbursement under any other plan. Such expenses will not be claimed as an income tax deduction. I authorize my Benefit Choice Plan account to be reduced by an amount no greater than the amount requested. Signature _____ Date _____
<i>Attach an explanation of benefits (EOB), and itemized report or evidence that provides the date of service, the name of the provider, service provided, and service cost. Balance forward statements, cancelled checks, and credit card receipts are NOT acceptable documentation for reimbursement.</i>	

Date Expense Incurred	Person Receiving Care	Relationship	Type of Service	Total Reimbursement Requested
				\$
				\$
				\$
				\$
				\$
Total Reimbursement Requested				\$

Mail or fax your claim form, with documentation, to:

ACS Benefit Services, Inc Phone: 800-849-5370 ext 1123
 8025 North Point Blvd., Suite 100 Fax: 336-759-7642
 Winston Salem, NC 27106

You may visit our web site at www.acsbenefitservicesinc.com to view your FSA balance.