

Send Completed Form To: PENN WESTERN BENEFITS, INC.  
P.O. Box 7834  
Greensboro, NC 27417  
Phone: 336-665-9400  
Fax: 336-664-1300  
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**SECTION 125 FLEXIBLE BENEFITS PLAN  
REQUEST FOR REIMBURSEMENT AND EXPENSE SUBSTANTIATION FORM**

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Employee Address: \_\_\_\_\_

**Instructions:**

Fill in the necessary information below for medical care or dependent care assistance expenses incurred by you or your eligible dependents. Each expense item must be accompanied by a receipt. The receipt must identify the expense as a qualified medical or dependent care assistance expense. (Note: Expenses covered under a medical or dental plan must be submitted under that plan first. Attach a copy of the explanation of benefits you receive from that plan showing the unpaid amounts).

Date Expense Incurred	Name and Relationship of Person Incurring Expense	Debit Card Y/N	Benefit Type*	Total Expense	Amount Paid By Another Plan	Amount Owed by You

**\*Benefit Type**

M=Medical or Dental                      D=Dependent Care Assistance

- I hereby request payment of \$ \_\_\_\_\_ from my spending account as reimbursement for the listed expenses.
- Debit card documentation

I certify that these expenses are not payable by any other benefit plan or program.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_