AFES SECTION 125 FLEXIBLE BENEFIT PLAN
MEDICAL TRAVEL LOG/EXPENSE REIMBURSEMENT VOUCHER

For reimbursement of medical travel expenses only

Name of Employee (Last, First, MI)	**Social Security #**
Mailing Address ☐ *Check here if this is a new address; if so, do you have other AF products?*	**E-mail address**
Name of Employer	**Daytime Phone #**

Date of Travel:	Patient's Name:	Location of Physician or Treatment Facility	Type of Treatment/Diagnosis:	Number of Miles:	Total Reimbursement Amount:
			Expense Total: *(must be completed)*		$ 0.00

I certify that the medical travel expense(s) listed above was incurred for transportation primarily for and essential to medical care for myself or an eligible dependent. The medical care was provided by a physician in a licensed hospital or medical facility, and no element of personal pleasure, recreation or vacation was involved in the travel. Travel to and from a pharmacy does not qualify as medical care and is not eligible for reimbursement.

I authorize the above expenses to be reimbursed from my account balance. To the best of my knowledge my statements on this form are true and complete. I certify that either I, my spouse, my tax dependent or my adult child who will be under the age of 27 as of the end of the calendar year has received the services described above on the dates indicated and that the expenses qualify as valid "medical care expenses" as defined by Internal Revenue Code Section 213(d). I certify that these expenses have not been reimbursed under this or any other health plan and I will not seek reimbursement under any other health plan. I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I further understand that I may be asked to provide further documentation or further detail relating to an expense.

Signature of Employee _____ **Date Signed** _____

Mailing Address: American Fidelity Assurance Company, AFES Flex Account Administration, PO Box 25510, Oklahoma City, OK 73125-0510 **PHONE NUMBER**: 1-800-325-0654 **FAX NUMBER: 1-800-543-3539**

American Fidelity will not be responsible for faxes not received. Health FSA average processing time is 5 to 7 working days from receipt of a completed voucher; HRA average processing time may vary based on plan design. Additional Forms and Account Information are available on our website at: americanfidelity.com – under Claim & Flex Forms.

INCOMPLETE VOUCHER MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM

KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS