Southeast Dubois County School Corporation

Wellness Benefit Claim Form

Employee Name: ____

Address: ____

____

Phone Number: ____

Signature: ____

Date: ____

Description of Eligible Expenses	Expenses for*	Date of Service	Total Amount Of Bill	Amount Paid by Any Plan	Your Actual FSA Claim Cost
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$

*Name of Patient

TOTAL REFUND REQUESTED: ________________

Please send this form to Dunn & Associates Benefit Administrators, Inc.

Email: financedept@dunnbenefit.com

Mail to: PO Box 2369 Columbus, IN 47202-2369

Fax: 812-378-9967