



To submit your claim, complete the information below and turn in your request with applicable receipts to:

Andy Williams
Mel-O-Cream Donuts International, Inc.

Phone: 217-483-7272 Fax: 217-483-7744

Employer: _____

Employee Name (Please type or print.): _____ Social Security No.: _____

Employee Address: _____

(Please check if this is a new address.) City _____ State _____ ZIP _____

Dependent/Child Care

LIST EACH RECEIPT SEPARATELY, (Use additional forms if necessary.)

Name of Dependent ^A	Age	Provider Name ^B	Provider ID No.	Date(s) Service Provided ^C	Requested Amount of Reimbursement ^D	FLEX ONE® Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Canceled checks or bills showing only a payment or previous balance are not acceptable.

Provider's Certification/Verification

I certify that the above-described dependent care expenses were incurred by the employee named above.

Business/Provider Signature _____ Address _____ Date _____

Unreimbursed Medical

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Patient Name ^A	Provider Name ^B	Description of Service ^C	Date(s) Service Provided ^D	Requested Amount of Reimbursement ^E	FLEX ONE® Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Canceled checks, credit card receipts or bills showing only a previous balance or balance due are not acceptable.

Provider's Certification/Verification

I certify that the above-described unreimbursed medical expenses were incurred by the employee named above.

Business/Provider Signature _____ Address _____ Date _____

I request reimbursement from my FLEX ONE® Flexible Spending Account(s) as listed above and certify that these are eligible medical or dependent care expenses that I or my dependents have incurred. I understand that medical expenses must qualify as deductible expenses for federal income tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that dependent care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return. I hereby authorize the Plan and its service provider (AFLAC and FLEX ONE), and their respective agents, employees, sub-contractors, and assigns to use the information provided above to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose and all such information as is reasonably required for such purposes. I further authorize any provider, insurer, or other entity to release any health or treatment information purpose of determining eligibility for Plan benefits or to detect or prevent fraud. I hereby expressly waive and release any claims related to the use, disclosure, or release of information so long as the information is used in furtherance of administering the Plan (including the processing or evaluating my claim for benefits under the Plan) or detecting or preventing fraud. This authorization does not and is not intended to in any way limit any right the Plan, AFLAC or FLEX ONE, or their respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information.

Date: _____ Employee Signature: _____

(See reverse for instructions.)

WHITE – FLEX ONE® Copy ♦ YELLOW – Employee Copy