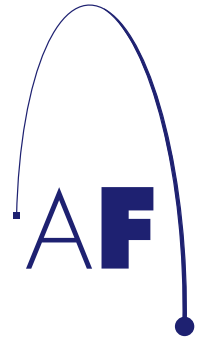


AMERIFLEX TRANSACTION SUBSTANTIATION REQUEST



Employer: _____
Employee Name: _____ Telephone: (_____) _____ - _____
Employee Address: _____
City: _____ State: _____ Zip: _____
Employee Social Security Number: _____ - _____ - _____
Please check box if the above information reflects a change of address:

Date of Expense _____
Type of Expense: Prescription CoPay Vision Dental Other _____
Proof of Expense Attached? Yes No (see statement below)
Is this a recurring expense? Yes No (If "Yes", you do not need to substantiate this expense moving forward)
If you are unable to provide a receipt or if the expense is ineligible, please attach a check or money order made out to AmeriFlex to reimburse your account. Failure to provide proper documentation for an eligible expense or to reimburse your plan for an ineligible expense can result in the termination of your AmeriFlex Convenience Card® and your plan.

"To the best of my knowledge and belief, the above statements are complete and true. I certify all of the following: Either I or my eligible dependent has received the services described above on the dates indicated; the expense(s) qualify as valid Medical expenses under my plan; if the expense is for my spouse/dependent, that person is my spouse or dependent as defined by my plan; I have not been and will not be reimbursed by any other source for this expense."

Employee Signature _____ Date _____