Flexible Benefit Health Care Spending Account

Anoka-Hennepin Independent School District No. 11
2727 N. Ferry Street, Anoka, MN 55303

Date_____

Employee Name_____

Address _____ Employee #_____

_____ School_____

Date of Service	Name of Medical Provider	Amount Not Covered by Insurance
Attach Original Receipts or Claims	**Total Claim**	**$**

I certify the above claims are true and correct, and the claim amount is not covered under any insurance or other benefit I am entitled to.

_____

Signature of Employee

Submit this form for reimbursement to the Anoka-Hennepin Insurance Department.
Please keep a copy for your records.