Mail or Fax to: **SOUTHERN ADMINISTRATORS AND BENEFIT CONSULTANTS, INC.**

SABC CLAIMS
P.O. BOX 2449
MADISON, MS 39130-2449
FAX - (601) 856-8088
(601) 856-9933

WWW.SABCFLEX.COM

BENNY CARD VALIDATION FORM ONLY

Please print and complete all required spaces (*)

The following form should only be used by participants to validate expenses that were paid for by the SABCFlex Card (Bennie Card),in accordance with IRS regulations. Claims sent with this form are substantiation of expenses only, and will not be processed.

Please compete this form and submit along with receipts from the provider where the eligible expenses where charged.

DOCUMENTATION INSTRUCTIONS

1. Submit receipt(s) from the provider where the charge(s) incurred (Explanation of Benefits (EOB) from your insurance carrier is preferred.
2. Third party receipt(s) must indicate the date of service, providers name and the type of service or item purchased.
3. Prescription drugs must include the name of drug, RX number and your cost.

*** EMPLOYER:** _____

*** EMPLOYEE NAME:** _____ *** SSN:** _____

*** DAY TIME PHONE #:** (_____)_____ **EMAIL** _____

VALIDATION ONLY

SECTION A

PROVIDERS NAME	DATE OF SERVICE	TYPE OF SERVICE/ITEM	AMOUNT
			$
			$
			$
			$

To the best of my knowledge and belief, my statements in this Expense Validation are complete and true. I am certifying that the above expense(s) where only for eligible expense(s) incurred after the effective date of my participation in the plan and only for eligible family members. I certify that these expense(s) have not been previously reimbursed or are not reimbursable under any other health plan coverage and or arrangement, and will not be claimed as an income tax deduction.

EMPLOYEE'S SIGNATURE:_____ DATE:_____

DO NOT WRITE BELOW THIS LINE, SABC OFFICE USE ONLY

Date Incurred: RECEIVED DATE:_____

VALIDATION ENTERED BY: _____