OSR 5-343# (Rev 3-4-2003)

Flexible Spending Account
Health Care Reimbursement Claim

Employee's Name	Social Security No.	Employee Work Phone	Plan Administrator Westinghouse Savannah River Company

Name (last first middle)	Sex	Birthdate	Deductible $	Coinsurance $	Copay $	Other Expenses $	Total
Employee							0.00
Spouse							0.00
Child							0.00
Child							0.00
Child							0.00
Child							0.00
						Total Amount of Reimbursement Requested With This Claim	0.00

EMPLOYEE CERTIFICATION

I authorize my Flexible Spending Account to be reduced by the amount of expenses listed above. The expenses incurred by myself or my eligible dependents are not reimbursable from any other source. I understand that these expenses cannot be claimed as credits or deductions on my income tax return. I further certify that I have read and understand the information outlined on the back of this form. The information on this form is true and correct to the best of my knowledge.

_____ _____

Employee Signature Date

FSA Administration
P. O. Box 100237
Columbia, SC 29202-3237

1-800-325-6596