BENEFIT ACCOUNT REPAYMENT FORM

Submit this completed form via one of the following methods:	Online Support Request	Mail
	Go to www.tasconline.com - Click **LOG IN** Sign into your Universal Benefit Account Create a Support Request and attach completed form	TASC Repayments PO Box 7308 Madison, WI 53707-7308

Instructions:

- **Download this form,** select the Repayment option and complete the requested information.
- **Submit repayment with a copy of this form**.
- Repayments will be applied to the oldest outstanding card transaction.

PARTICIPANT INFORMATION

First Name:		MI:		Last Name:	
TASC 12-digit ID:		Email Address:			
Primary Phone:		Mobile Phone:			
Employer Name:		Employer 12-digit TASC ID:			

REPAYMENT AND BENEFIT INFORMATION

Benefit Account to Repay (Healthcare FSA, Dependent Care, HRA, etc.):	
Repayment Amount:	$

REPAYMENT OPTIONS

☐ **Repay the Plan with a check or money order.** Mail repayment payable to TASC at the address at the top of this form.
NOTE: A $25 service fee may apply to checks returned due to insufficient funds.

☐ **Repay the Plan with a Replacement Receipt.** To submit a new, eligible expense (replacement receipt), complete the section below. Submit via support request as indicated at the top of this form (do not submit as a reimbursement request).

I authorize replacement of my unverified or ineligible transaction(s) with this receipt (amount, service date, description and provider noted below). To the best of my knowledge and belief, this replacement receipt is for eligible expenses incurred during the applicable Plan Year for eligible participants and/or eligible dependents as defined under the Plan and applicable law. I certify the TASC benefit card was not used to pay for this expense, these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction or credit. I further understand it is my responsibility to comply with all Plan and regulatory guidelines.

_____ $_____
Description (replacement receipt) **Expense Amount**

_____ _____
Provider (replacement receipt) **Date of Service**

_____ _____
Participant Signature **Date**