

Flexible Benefits Plan Reimbursement Request

Name: _____ Employer: _____
 Street Address 1: _____ SS#: _____
 Street Address 2: _____ Phone #: _____
 City, State, Zip: _____ New Address?: Yes No

Instructions: Provide the information requested below for the health care and/or dependent day care expenses incurred by you on behalf of yourself, your spouse and your dependents. You must provide insurance EOBs, hospital/doctor bills, pharmacy receipts or other evidence that expenses were incurred (cancelled checks and/or credit card slips are not acceptable). Please provide all requested information; an incomplete form will be returned to you.

Dependent Day Care Expenses

<u>Name(s) of Dependent(s)</u>	<u>Period of Care (from / to)</u>	<u>Service Provider Name and Tax ID#</u>	<u>Amount Incurred</u>
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Unreimbursed Health Care Expenses

<u>Date of Service</u>	<u>Name of Service Provider</u>	<u>Expense Description</u>	<u>Person for Whom Expense Incurred</u>	<u>Net Amount</u>
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Individual Insurance Policy Premiums

<u>Period of Coverage</u>	<u>Name of Provider</u>	<u>Person Covered</u>	<u>Amount Incurred</u>
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

To the best of my knowledge and belief, the above information is true and complete. I hereby certify the following: a member of my family has received the services described above on the dates indicated; the expenses are out-of-pocket and qualify as valid dependent day care or health care expenses or individual policy premiums under the plan; these expenses have not been submitted previously for reimbursement under this plan or any other plan, insurance or otherwise, and I will not seek reimbursement for these expenses under any other plan; and, the unreimbursed health care expenses are for medical care (excluding cosmetic purposes), are not incurred for general health purposes and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim federal income tax deduction or credit. I also understand that I may be asked to provide further detail about some expenses. With respect to Dependent Day Care expenses, I agree to file Form 2441 with my tax return and provide any taxpayer identification number required thereon and I certify that I have read, understand and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses. I hereby authorize the above expenses to be reimbursed from my Dependent Care Flexible Spending Account, Health Care Flexible Spending Account or Individual Policy Premium Account, as applicable.

Date: _____

 Employee Signature

Please fax/send completed form and supporting documentation to: