Support. Services. Alliance.
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Mail Claim To:
SSA, Inc.
PO Box 340
Cobleskill, NY 12043
(800) 322-3920
FAX (518) 234-3026

FLEXIBLE SPENDING PLAN

REIMBURSEMENT REQUEST FORM

PERSONAL INFORMATION

Employer | **For Plan Year** _____ | **St. Lawrence ID Number**

Employee Name **(Last)** **(First)** **(Initial)**

Home Address **Street** **City** **State** **Zip**

☐ Health Care Account ☐ Dependent Care Account ☐ ID# of Daycare Provider_____

PERSONAL INFORMATION

Name of Employee, Child or Dependent Receiving Service	Relationship to Employee	Dates of Service From	Dates of Service To	Amount To Be Reimbursed	mySource Card

Grand Total ☐

AUTHORIZATION

I certify that the expenses for reimbursement requested from my Health Care Reimbursement Account (HCRA) and/or Dependent Care Reimbursement Account (DCRA) were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by another plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HCRA and/or DCRA. I (or we) understand that expenses reimbursed through the HCRA and/or DCRA accounts can not be used as deductions or credits when filing my (our) income tax return.

Employee Signature _____ **Date** _____

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the bill(s) or an explanation of benefits from your other insurance.