

**KALAMAZOO COLLEGE
FLEXIBLE BENEFIT PLAN
REQUEST FOR MEDICAL MILEAGE REIMBURSEMENT FORM**

EMPLOYEE _____ PHONE #: _____

ADDRESS _____

(Please check if this is a new address.)

CITY _____ STATE _____ ZIP _____

MEDICAL MILEAGE REIMBURSEMENT

*Complete one line for each expense you wish reimbursed under your Medical Reimbursement Account.
*For medical mileage please include a copy of your office visit copay showing location and date of service as well as a Mapquest.com printout showing mileage for the trip. *For prescription mileage please include the prescription receipt and label, as well as a Mapquest.com printout showing mileage.

TYPE OF SERVICE MILEAGE	SERVICE DATE Ex; 1/15/xx – 2/07/xx Must List Date/s	PROVIDER Name of Doctor or Pharmacy	AMOUNT Total number of miles for one round trip
TOTAL AMOUNT REQUESTED: \$			

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the KALAMAZOO COLLEGE FLEXIBLE BENEFIT PLAN with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

In addition, by signing below, the employee is indicating the following statements are true:

- The transportation expense is incurred solely for the purpose of receiving essential medical/pharmacy services.
- The pharmacy and/or provider’s office is ***not*** on the same route as other daily driving destinations, whether it is work, pleasure, or shopping.
- No other item for personal use is purchased during the visit.

Employee’s signature

Date

**Mail to: JFP Benefit Management, Inc. - P.O. Box 189 - Jackson, Michigan 49204 (800) 589-7660 or (517) 784-0535
Fax (517)784-0821 or Email jbergstrom@jfpbenefitmanagement.com**