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FLEXIBLE SPENDING REIMBURSEMENT REQUEST FORM

Section I. Employer/Employee Information

Employer Name:	Group Number:	Employer Location (if applicable)

Employee Name:	Employee SSN:	Flex Plan Year: 20_____	
Address:	City:	State:	Zip:

Employee E-mail Address:	Day Time Phone:

Section II. Reimbursement Request

- Please attach all receipts that apply to requested reimbursements. For dependant care please attach receipts or have a Tax ID and signature of the Dependant Care Provider.

Date of Service	Type of Health Flexible Spending Account (FSA) Expense(s)				Amount of Expense(s)
	Medical	Dental / Vision	RX	OTC / Other	
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
				Total Reimbursement Requested	$

Date of Service	Dependent Care Assistance (DCA) Expense(s)		Amount of Expense(s)
	Name of the Dependent Expense(s) Were Incurred For	Dependent(s) Age	
			$
			$
			$
		Total Reimbursement Requested	$

Providers Tax ID Number_____ Providers Signature (or Attach Receipt)_____

Section III. Participant Certification

I certify that the expenses for which I am requesting reimbursement for meet the following conditions:

- The above expenses were incurred for services or supplies for me and/or my eligible dependents listed above which either reside with me in a parent child relationship or are legally dependent on me for their support.
- The above services and supplies were furnished to me or my dependents on or after my effective date with the Plan.
- I have not been reimbursed for the above expenses, nor have any of my dependents been reimbursed for these expenses.
- I understand that any amounts not used for qualified expenses by the end of the Plan Year or Grace Period will be forfeited to my Employer.
- I have not and will not itemize and deduct, nor claim credit for these expenses on my income tax returns.

Reimbursement will be made in accordance of the provisions of the Plan.

Employee Signature: _____ **Date:** _____