**Eide Bailly Employee Benefits**
U.S. Bancorp Center
800 Nicollet Mall, Suite 1350
Minneapolis, MN 55402-7033
Phone: 612.253.6633 | 1.800.300.1672
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www.eidebaillybenefits.com

# Reimbursement Request Form

Please Complete All Information And Attach Itemized Documentation For Each Expense Listed

Benefit Year: _____

Employer: _____

Social Security Number: XXX - XX - _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Daytime Phone: (_____) _____ E-mail: _____

Unreimbursed Medical/Dental Expense (for you, your spouse and your dependents)

| | Date(s) of Service (MM/DD/YY) | Person for Whom Expense Incurred | Expense Description | Name of Service Provider | Net Amount* |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| | | | **Total Unreimbursed Medical/Dental Expense Claimed** | | |

**Note:** If you need additional space, attach a separate sheet of paper.

**Net amount is the amount of the claim not reimbursed to you through another plan; i.e. health or dental insurance.*

Unreimbursed Dependent Care Expense (Daycare Expenses)

| | Period Covered from (MM/DD/YY) to (MM/DD/YY) | | Name of Dependent | Identify below the Provider Name, Tax ID and Signature *OR* attach a receipt from the Provider with the Provider Name, Tax ID and Signature. The information is required with each submission. | Actual Amount Incurred |
|---|---|---|---|---|---|
| 7 | | | | | |
| | | | | Provider Signature - | |
| 8 | | | | | |
| | | | | Provider Signature - | |
| 9 | | | | | |
| | | | | Provider Signature - | |
| | | | **Total Unreimbursed Dependent Care Expense Claim** | | |

Note: If same Dependent Care Provider for each claim listed above, signature is required only once.

**Read Carefully**

The undersigned participant in the plan certifies that all expenses for which reimbursement of payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's cafeteria plan. The undersigned fully understands that he/she alone is 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 of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related federal, state, or city income tax on amounts paid from the plan which relate to such expense.

_____ _____

Employee Please Sign Here Date