FLEXIBLE BENEFITS PLAN

Request For Reimbursement

Employer _____ Group # _____ Date _____

Employee Name _____ Social Security # _____
Last First MI

Home Address _____ Phone # _____
Number/Street City State Zip

Types of Expenses

Medical or Medical Related Expense	Dependent Care Expenses (DayCare)	Transit Expense	TOTAL CLAIM
$	$	$	$

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Compensation Account be reduced by the amount requested.

Employee Signature _____ Date _____

Please clarify if this is an expense from the prior year or an expense for

Prior ☐ Current ☐

Please choose one of the following ways of getting your reimbursement:

Manual Check ☐ Direct Deposit ☐

Mail to address provided above ☐
I will Pick Up when ready ☐

**Claims will automatically be denied if incorrectly filled out or incorrect form is used.
Please contact your supervisor for correct form and any needed information.**