

FLEXIBLE BENEFIT PLAN – REIMBURSEMENT REQUEST

(Please read the attached guideline for eligible reimbursement expenses)

Complete the following for expenses incurred by you, your spouse, or eligible dependents. See the attached instruction sheet for a description of expenses which are eligible for reimbursement. Be sure to complete all information requested on this form. Any missing information may result in a delay in processing your request. **NOTE: Keep expenses for different plan years separate – ONLY ONE PLAN YEAR PER CLAIM FORM.** Please type or print the information. Remember to sign and date the form.

Plan Year	Group #	SSN
Group Name		
Employee Name		

Date of Service	For Whom	Relationship <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Type of Service		Service Provider		
Please check the type of verification you are providing for this reimbursement claim.		Medical Amount Claimed	Dependent Day Care Claimed	Private Insurance Claimed
<input type="checkbox"/> Invoices or insurance statements for claims are attached; OR <input type="checkbox"/> My <u>daycare</u> provider has signed the following affidavit : <i>I certify that the daycare service described above was provided by me or my company on the dates indicated.</i> PROVIDER SSN/EIN: _____ _____ \$ _____ Signature Amount				

Date of Service	For Whom	Relationship <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Type of Service		Service Provider		
Please check the type of verification you are providing for this reimbursement claim.		Medical Amount Claimed	Dependent Day Care Claimed	Private Insurance Claimed
<input type="checkbox"/> Invoices or insurance statements for claims are attached; OR <input type="checkbox"/> My <u>daycare</u> provider has signed the following affidavit : <i>I certify that the daycare service described above was provided by me or my company on the dates indicated.</i> PROVIDER SSN/EIN: _____ _____ \$ _____ Signature Amount				

Date of Service	For Whom	Relationship <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Type of Service		Service Provider		
Please check the type of verification you are providing for this reimbursement claim.		Medical Amount Claimed	Dependent Day Care Claimed	Private Insurance Claimed
<input type="checkbox"/> Invoices or insurance statements for claims are attached; OR <input type="checkbox"/> My <u>daycare</u> provider has signed the following affidavit : <i>I certify that the daycare service described above was provided by me or my company on the dates indicated.</i> PROVIDER SSN/EIN: _____ _____ \$ _____ Signature Amount				

I request payment for my medical, dependent care, and/or allowable private insurance expenses listed above. I certify that these expenses are valid claims, which I have incurred and paid, and are not eligible for further reimbursement under any other plan. Further, the expenses incurred comply with the rules of the plan and have not and will not be claimed as deductions or credits on my income tax return. I understand that if the expenses for which reimbursement is claimed are not proper expenses under the plan, I may be liable for the payment of all related taxes, including federal, state, or city income tax and amounts paid from the plan which relate to such expense. I have and will maintain documentation to support these expenses to satisfy IRS requirements. If I do not use the amount set aside in my account(s) by the end of the plan year, I realize that it will be forfeited to my employer.

Signed _____ Date _____

Totals

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Print two copies. One for you and send the other one to:

Flexible Benefit Plan
 Region I
 P. O. Box 1178
 Moorhead, MN 56561-1178

800-450-2990 or 218-236-2990 - Fax 218-236-2368

www.region1.k12.mn.us

Office Use

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