

## Flex Spending Arrangement Reimbursement Form



Charge Against Balance For Calendar Year 2009

Employee name: \_\_\_\_\_

Office phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Reimbursement requests will not be processed without acceptable evidence of your expenses. Acceptable evidence includes **receipts, statements or the original explanation of benefit forms** which contain the following information: *Type* of service or product provided, *Date* expense was incurred, *Name* of employee or dependent for whom the service/product was provided, *Provider* (person or organization providing service/product), *Amount* of expense.

<i>Medical</i>					
<i>Date of Service</i>	<i>Name of Provider</i>	<i>Name of Patient</i>	<i>Type of Service</i> (co-pay, Rx, ortho, OTC, etc.)	<i>Relationship of This Person to Employee</i>	<i>Amount of Expense Medical</i>
Medical Total					

### Child and Dependent Day Care Expense

<i>Service Dates</i>		<i>Name of Day Care Provider</i>	<i>Child/Dependent's Name</i>	<i>Is your child/dependent 13 years or younger?</i>	<i>Amount of Expense Dependent Care</i>
<i>From</i>	<i>To</i>				
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Care Total					

Grand Total

***Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation.***

*2008 expenses must be from 01/01/2009 - 03/15/2009*

*2009 expenses must be from 01/01/2009/ - 03/15/2010*

I request reimbursement for the expenses listed in this claim form under my employer's Flexible Spending Arrangement. I certify that I and/or my eligible dependents (as determined under IRS rules) have incurred these expenses. I further certify that I have not received reimbursement for these expenses from any other source nor are they eligible for reimbursement from any other source and that I will not claim these expenses as income tax deductions.

I certify that the information provided for this claim is accurate and complete to the best of my knowledge.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

HR Use Only:	Date Processed _____	Available Balance	\$ _____
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