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SECTION A - EMPLOYER/EMPLOYEE INFORMATION

Employer Name	Group Number	Employer Location (if applicable)

Employee Name	Employee UID or SSN	Flex Plan Year

Address	City	State	Zip

Employee Email Address	Daytime Phone

SECTION B - REIMBURSEMENT REQUEST

Please attach all receipts that apply to required reimbursements. For dependent care, please attach receipts and signature of the Dependent Care Provider.

HEALTH FSA EXPENSES

Date of Service	Medical	Dental/Vision	Rx	Other	Amount of Expenses
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
	☐	☐	☐	☐	$
				Total Reimbursement Requested:	$

DEPENDENT CARE ASSISTANCE EXPENSES

Date of Service	Name of Dependent Expenses Were Incurred For	Dependent(s) Age	Amount of Expenses
			$
			$
			$
			$
			$
		Total Reimbursement Requested:	$

Provider's Tax ID Number or SSN	Provider's Signature (or attach receipt)

SECTION C - EMPLOYEE CERTIFICATION

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

- The above expenses were incurred for services or supplies for me and/or my eligible dependents listed above who 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.
- I understand that reimbursement will be made in accordance with the provisions of the Plan.

Employee Signature _____ Date _____