



Return to:

EMPLOYEE BENEFIT MANAGEMENT CORP
Attention: Flexible Spending Department
4789 Rings Road
Dublin, Ohio 43017-1599
Phone: (614) 766-5800 Fax: (614) 766-0901

FLEXIBLE SPENDING
REQUEST FOR REIMBURSEMENT FORM

EMPLOYEE NAME: LAST FIRST MI SS#:

If address has changed, please complete:

ADDRESS: CITY: STATE: ZIP:

EMPLOYER: DAYTIME PHONE#:

HEALTH CARE REIMBURSEMENT ACCOUNT

Please indicate below the amount of reimbursement you are requesting. Receipts must be attached.

MEDICAL \$ VISION \$

DENTAL \$ OTHER \$

TOTAL HEALTH CARE EXPENSE \$ FROM: TO: [DATES INCURRED]

DEPENDENT CARE REIMBURSEMENT ACCOUNT
(Day Care Expense)

Please indicate below the amount of reimbursement you are requesting. Receipts must be attached.

NAME OF DEPENDENT(s)

AMOUNT OF EXPENSE \$ FROM: TO: [DATES INCURRED]

Under IRS Rules, you are required to report the name, address and taxpayer identification number of each day care provider on your federal income tax return.

I hereby request reimbursement for the above-noted expenses.

I certify that my request to be reimbursed complies with the Flexible Spending Program and Internal Revenue Code requirements. I further certify that the expenses outlined above have not been reimbursed, are not reimbursable under any other Plan, and that the dependent care expenses (if applicable) qualify as an eligible expense under the terms of the Plan. Furthermore, I understand that expenses reimbursed under this Plan cannot be deducted or taken as a tax credit on my income taxes. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

Signature of Employee

Date

## **HEALTH CARE REIMBURSEMENT ACCOUNT**

To qualify for reimbursement from your Health Care Reimbursement Account, the following is required:

1. Receipts submitted must be for medical, dental, vision, and/or hearing expenses which are allowed by the IRS.
2. The expenses must be incurred by you or a dependent for whom you will be entitled to a personal exemption on your federal income tax return.
3. If there is a question as to the eligibility of a particular expense or the dependency status of a particular individual, you will be contacted for more information.

## **DEPENDENT CARE REIMBURSEMENT ACCOUNT (Day Care Expense)**

To qualify for reimbursement from your Dependent Care Reimbursement Account, the following is required:

1. Dependent care expenses must be incurred to enable you (or your spouse) to work.
2. The person providing the dependent care service must not be a child of yours under age 19 or a dependent for whom you will be entitled to a personal exemption on your federal income tax return.
3. The child(ren) being cared for must be less than 13 years old (unless physically or mentally unable to care for themselves).
4. You will be required to provide the taxpayer I.D. or Social Security number of the dependent care provider on your federal individual tax return.
5. Your expense limit for the federal tax credit is reduced by the amount reimbursed through your Dependent Care Reimbursement Account.
6. The balance in your Dependent Care Reimbursement Account must be at least equal to the expenses submitted with the Request for Reimbursement Form. If the balance in your Account is less, these expenses will be held until the balance in your Account is sufficient to pay these expenses.