

Custom Benefit Administrators

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Request for Reimbursement for Medical and Dependent Care Flexible Spending Account

Participant's Name: _____

Employer's Name: _____

Directions: Please carefully read the back for information in properly filling out this form.

Medical Reimbursement Expenses

Date of Service	Name of Patient	Expense Description	Name of Service Provider	Amount Incurred
TOTAL				

Dependent Care Reimbursement (Day Care Expenses)

Dates of Coverage		Name of Dependent(s)	Name and Address of Child Care Provider of Service	Amount Paid
From	To			
TOTAL				

This is to certify that 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 to be reduced by the amount requested.

Participant's Signature

Date