


REQUEST FOR REIMBURSEMENT

(Please print all required spaces () and sign).*

* Plan Year: _____ thru _____

(Submit separate request forms for each Plan Year.) **PLEASE SIGN FORM BELOW** 

* COMPANY NAME: _____

* EMPLOYEE NAME: _____ * SSN: _____

* DAY TIME PHONE #: (_____) _____ EMAIL _____

DEPENDENT DAY CARE EXPENSES TOTAL: \$ _____ *

UNREIMBURSED MEDICAL EXPENSES TOTAL: \$ _____ *

PREMIUM REIMBURSEMENT EXPENSES TOTAL: \$ _____ *

TO PICKUP REIMBURSEMENT at SABC,
PLEASE INSTRUCT IN BOX ABOVE.

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred after the effective date of my participation in the plan and only for eligible family members. I certify that these expense(s) have not been previously reimbursed or are not reimbursable under any other health plan coverage, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account be reduced by the amount of eligible expenses requested.

* **EMPLOYEE'S SIGNATURE:**  _____ DATE: _____

DO NOT WRITE BELOW LINE

Ineligible Reason

Date Incurred: Month: _____ Year: _____

DC Total: _____ DC Ineligible: _____

URM Total: _____ URM Ineligible: _____

PRM Total: _____ PRM Ineligible: _____

Process By: _____ Input By: _____

cafe
SIGNATURE REQUIRED