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: ______________________________ **SS#:** ________________
LAST FIRST MI

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**