FLEXIBLE COMPENSATION PLAN
REIMBURSEMENT REQUEST

Employee Name: ___________________________________ Social Security No.______________________________

Home Address: _________________________________ Home Phone: ____________ Work Phone:____________

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_________________________________ Employer: ____

I certify that I have incurred the below listed expenses that qualify for reimbursement under my employer's Flexible Compensation Plan and that these expenses were **incurred** during a period in which I was an eligible employee participating in Mediflex and/or Careflex. I certify that these expenses have not and will not be reimbursed under any other insurance or benefit plan and understand they may not be claimed for income tax purposes. I also understand that claims for expenses incurred in a given Plan Year must be Post Marked no later than March 1 after the end of that Plan Year or within 60 days after the date of my termination, whichever is earlier.

Unreimbursed Medical Expenses (Mediflex)

Type claim	Amount

****Dependent Day Care Expenses (Careflex)****
*****This information must be provided for all dependent care claims.*****

Dependent(s) Name: ____ Date(s) of Birth_________________

Relationship: ____________________________

Date of Care	Amount

*****Day Care Provider Information*****

Name of day care provider: ________________________________ Address: ______________________________

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Provider's taxpayer identification number: ________________________

Employee Signature: X____**Date**: ________________

This claim form must be included with all claims. Mail the **signed** form with proper documentation showing expense incurred and date that expense was incurred, i.e. a copy of your Explanation of Benefits, etc**. (SEE BACK FOR TYPES OF DOCUMENTATION REQUIRED.) A receipt without dates of service and charges, copies of Cancelled checks, "Balance Forward" and "Previous Balance" statements are not acceptable proof of incurred expenses.**

Flexible Compensation Plan
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