REIMBURSEMENT CLAIM FORM
Flexible Spending Accounts

EMPLOYER:			
NAME:	Last First MI	**SS#:**	
ADDRESS:	Street City State ZIP	**PHONE :**	( )

☐ **Please check if this is a new address**

Information below must be completed. Please attach the required documentation needed to substantiate the expenses listed before submitting this claim. Credit Card/Debit Card Receipts and Cancelled Checks are not allowed documents per IRS Regulations.

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Claimant's Name	Relationship	Description of Service	Claim Amount
				$
				$
				$
				$
				$
			Totals:	$

DEPENDENT CARE (CHILD CARE) CLAIMS

Date of Service From	To	Dependent's Name	Dependent Care Provider Name	Dependent Care Provider Address and Tax ID# or SS #	Claim Amount
					$
					$
					$
				Totals:	$

INDIVIDUALLY OWNED HEALTH INSURANCE CLAIMS

Premium Expense From	To	Name of Person Premium Covers	Insurance Carrier Name	Description of Policy	Claim Amount
					$
					$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents where eligible), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____**Date:** _____/_____/_____

FAX TO: (859) 255-2999

OR MAIL TO: MCGREGOR & ASSOCIATES, INC.

333 W. VINE STREET, SUITE 1610, LEXINGTON, KY 40507