# FLEXIBLE BENEFIT PLAN
# REIMBURSEMENT REQUEST FORM

**Please print or Type to complete form**

Employer Group Name _____

Name _____ Phone _____

Mailing Address _____

Street City State Zip Code

Check here if any of your contact information has changed - ☐

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*Instructions:* The form must be signed and dated. Attach original receipts, bills, statements, as supporting documents. **Each receipt must show the original date of service and the type of service provided.** Documentation will not be returned. Eligible expenses are those expenses incurred by you, your spouse, or your eligible dependents and qualify as eligible deductions by the IRS, and are not or cannot be reimbursed from any other source. Expenses must be incurred during the period in which you made an election to participate in the plan. Reimbursed expenses cannot be taken as a deduction on income tax returns. The minimum check amount is $10.00. Claims will be held until $10 minimum is reached. Last check of plan year will be issued for account balance if under $10.00.

## Health Care Expenses

The information on the documents (receipts) must include the following:

**Date(s) of service** **Type of service provided** **Amount of the expense** **Name of the service provider**

| Patient | Relationship | Dates of Services From | To | Description | Amount |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | **TOTAL** | **$0.00** |

## Day Care Expenses

Please provide the following information: A statement from the day care provider listing:

**Date(s) of service** **Charges** **Provider's signature**

| Dependent | Relationship | Dates of Services From | To | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | **TOTAL** | $0.00 |

## Verification of Day Care Expenses

Provider Name _____ Tax ID #_____

Provider Address _____

I request payment from my reimbursement account for the above expenses. To the best of my knowledge, these expenses are eligible under the plan. I understand that these expenses must qualify under applicable sections of the Internal Revenue Code and certify that they are not eligible for reimbursement from any other source.

Signature_____Date_____

*Flex 315 N. Marketplace Drive Centerville UT 84014*
*Email: flex@gwcu.org*
*Phone: 801-532-3412 or Toll Free: 888-532-3412*
*Fax: 801-532-3416*