Flexible Spending Account Reimbursement Request

Company Name: Employee SS # _____-_____-_____

Employee Name: *Please print* _____, _____
(Last Name) *(First Name)*

Employee Mailing Address: _____

Please check if change of address □ _____
(City) *(State)* *(Zip Code)*

Home/Cell Telephone (_____) _____- _____ Home Email Address:_____

Dependent / Child Care Expenses:

Name & Age of Dependent	Provider Name	Provider Tax ID or Social Security #	Dates of Service	Amount

Please attach a receipt or itemized bill listing the above information. Cancelled checks will not be accepted.

I certify that the above described Dependent Care Expenses were incurred by the employee named above.

Provider Signature:_____Address:_____Date:_____

Unreimbursed Medical Expenses:

Patient Name	Provider Name	Description of Service	Dates of Service	Amount
			Total Reimbursement Due	

*Multiple receipts from the same provider (i.e. Walgreen's or Dr. Smith) can be totaled together on **one** line.

*Please attach a **COPY** or your receipt, itemized bill or Explanation of Benefits listing the above information.

As of January 2, 2011, some of the items previously allowed became ineligible for reimbursement through your FSA plan due to changes with Healthcare Reform.

I certify that the above described Unreimbursed Medical Expenses were incurred by the employee named above.

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Care expenses that I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expenses for Federal Income Tax Purposes, and cannot be reimbursed by another source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Signature:_____ Date:_____

P.O. Box 730 Falmouth, MA 02541 E-Mail: benefits@omegabfs.com Phone: (508) 986-9359