

**CITY OF O'FALLON
CAFETERIA PLAN
REQUEST FOR REIMBURSEMENT**

Employee Name (please print): _____

Employee Address: _____
Street
City
State
Zip

Last 4 digits of SSN: _____

DEPENDENT/CHILD CARE FLEX

List Each Receipt Separately

Name of Dependent ^A	Age	Provider Name ^B	Provider ID#	Dates Service Provided ^C	Requested Amount of Reimbursement ^D	Office Use ONLY

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

PROVIDER'S CERTIFICATION/VERIFICATION

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

Business/Provider
Address
Date

UNREIMBURSED MEDICAL

List Each Receipt Separately

Patient Name ^A	Provider Name ^B	Description of Service ^C	Dates Service Provided ^D	Requested Amount of Reimbursement ^E	Office Use ONLY

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Cancelled checks, credit card receipts or bills showing a previous balance or balance due only are not acceptable.

PROVIDER'S CERTIFICATION/VERIFICATION

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

Business/Provider
Address
Date

I request reimbursement from my FLEX ONE 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 any other 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 providers(s) will be supplied to the IRS on my annual tax return.

Date: _____ Employee Signature _____