HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

This claim form is only for requesting reimbursement from your Flexible Spending Account for health care expenses. In order to be reimbursed, a bill, paid receipt or other evidence of payment must be attached to the claim form.

No reimbursement will be give unless this form is signed.

Employee Name_____ Employee ID #_____

Campus Address P.O. Box_____ Campus Extension_____

DEPENDENT NAME	SOC SEC #	RELATIONSHIP	DOB	STUDENT STATUS	AMOUNT TO BE REIMBURSED

TOTAL: _____

RECEIPTS FOR HEALTH CARE EXPENSES MUST BE ATTACHED

I certify that the medical care expenses being submitted for reimbursement meet the following requirements.

1. The medical care expenses were incurred by me or by eligible members of my family during the period I was participant in the Health Care Flexible Spending Account Plan. For the purpose of the Plan, medical care expenses have the same meaning as defined in Section 213 of the Internal Revenue Code.

2. The medical care expenses were not paid by the health care coverage provided through my employer or by any other policies, such as the coverage provided by the spouse's employer. The expenses submitted are either not covered by any other policies or represent amounts paid by such policies, such as deductibles or co-payments.

I understand that I am responsible for any tax reporting or other legal requirements with respect to reimbursement expenses.

I also understand that to the extent medical care expenses are reimbursed under the Health Care Flexible Spending Account, they may not be claimed as expenses against the federal Income tax credit for medical expenses.

I authorize the release of any medical information necessary to process this claim. I attest that the expenses for which I am asking reimbursement have actually been, or will be, paid by me.

_____ _____

Employee Signature Date

* Attach "Explanation of Benefits" from your health insurance carrier. ALL DOCUMENTS MUST BE ORIGINALS.