EDUCATIONAL SERVICE UNIT NO. 10

FLEXIBLE SPENDING ACCOUNT
REQUEST FOR REIMBURSEMENT

EMPLOYEE:______________________ SOCIAL SECURITY NUMBER:____________ EMPLOYEE NUMBER:________

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing: a) date of service; b) description of service provided; c) name of employee or dependent receiving service; d) current charge. Claims cannot be processed without acceptable evidence of your expenses. Cancelled checks, credit card receipts or bills showing only payment or previous balance are not acceptable.

MEDICAL OR DENTAL EXPENSES

Employee or Dependent	Provider (Dr, DDS, Phar., Hosp.)	Date(s) of Service	Expense Amount
			$
		TOTAL	$

DEPENDENT CARE (Babysitting/DayCare/Preschool)

Please attach a receipt from your day care provider listing: a) child's name; b) dates of service; c) charge; d) SSN or Federal ID #; e) signature for proof of payment (mandatory). Claims cannot be processed without acceptable proof of payment.

Child's Name(s)	Day Care/Sitter	I.D. or SS # (Mandatory)	Date(s) of Service	Expense Amount
				$
			TOTAL	$

INDIVIDUALLY-OWNED HEALTH INSURANCE PREMIUMS

Insured(s)	Name of Provider	Period of Coverage	Expense Amount
			$

I certify that the above information is correct and I am fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim. I have not received reimbursement previously for these expenses from the Flexible Spending Plan or any other health plan coverage. Unless an expense for which payment is made is a proper expense under the Plan, I may be liable for the payment of all related taxes. The total of any reimbursed Dependent Care expenses does not exceed my or my spouse's earned income (W-2) pay for the year. No payment may be made under the Plan if the service provider is my dependent for federal income tax purposes, or is my child or stepchild and is under the age of 19. Reimbursed Dependent Care expenses cannot be used to claim a credit on my personal income tax return and Reimbursed Medical Care expenses cannot be used to claim a deduction on my personal income tax return. I understand that I must furnish adequate proof of individually-owned health insurance coverage and that the Administrator must authorize this payment.

EMPLOYEE'S SIGNATURE______________________________________ DATE____________________

SUBMIT REQUEST FOR REIMBURSEMENT TO:

ALMQUIST, MALTZAHN, GALLOWAY & LUTH, P.C. P.O. BOX 1407 GRAND ISLAND, NE 68802-1407

FAX: 308/381-4824 **E-MAIL**: flexplan@gicpas.com