ESU #1

FLEXIBLE SPENDING ACCOUNT REQUEST FOR REIMBURSEMENT

EMPLOYEE_____ SOCIAL SECURITY NUMBER_____ EMPLOYEE NUMBER_____

REMEMBER ---- FLEXIBLE BENEFIT PLANS ARE BASED ON SERVICE DATE, NOT PAYMENT DATE

MEDICAL, DENTAL, PRESCRIPTION, VISION EXPENSES

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. Please attach a third-party receipt, itemized bill, or Explanation of Benefits (EOB) listing:

1) Date of Service 2) Description of Service Provided 3) Employee/ Dependent Receiving Service 4) Charges 5) Insurance Payment Applied

Employee or Dependent	Provider (Dr, DDS, Phar., Hosp.)	Date(s) of Service	Expense Amount
_____	_____	_____	$_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
		TOTAL	$ 0.00

DEPENDENT CARE EXPENSES Babysitting - Day Care - Preschool

Claims cannot be processed without acceptable proof of payment. Please attach a receipt from your Day Care provider listing:
1) Child's Name 2) Dates of Service 3) Charges 4) Provider's SSN or Tax ID# 5) Signature for proof of payment (mandatory)

Child's Name(s)	Day Care/Sitter	Provider's SSN or Tax ID# (Mandatory)	Date(s) of Service	Expense Amount
_____	_____	_____	_____	$_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
			TOTAL	$ 0.00

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. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the Plan for any such expense. 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. This certification also applies to any Flex Debit Card payments where receipts are submitted for verification.

EMPLOYEE'S SIGNATURE YOU MUST PRINT & SIGN THE FORM **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

VIEW YOUR ACCOUNT ONLINE: www.MyFlexOnline.com **CONTACT US AT**: 308.381.1810