MoneyPlus$

FLEXIBLE SPENDING ACCOUNT • REIMBURSEMENT REQUEST FORM

PLAN YEAR 2003

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.
PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF THIS FORM

A. NAME _____ HOME PHONE ( ) _____

DAY PHONE ( ) _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NO. _____ EMPLOYER MUSC

B. MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT

Was the amount applied to your deductible? Yes ☐ No ☐ Was the amount you paid a co-payment? Yes ☐ No ☐

SUMMARY OF EXPENSES

Name of person receiving services	Relationship to employee	Provider of services*	Deductible or Co-Pay	Dates of service ** From Mo/Day/Yr	Dates of service ** To Mo/Day/Yr	Amount to be reimbursed
				TOTAL		$0.00

* "Provider" means hospital, doctor, dentist, drugstore, medical supply store, etc.
** Use date on which service was provided, not the date you paid for it.

C. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Is the facility Tax Exempt? Yes ☐ No ☐ Tax ID# or social security # of Day Care provider:

SUMMARY OF EXPENSES

Name of person receiving services	Age and grade	Relationship to employee	Provider of services* and address	Dates of service ** From Mo/Day/Yr	Dates of service ** To Mo/Day/Yr	Amount to be reimbursed
				TOTAL		$0.00

* "Provider" means day care center, person who gave care, etc.
** Use date on which service was provided, not the date you paid for it.

SIGNATURE OF DAY CARE PROVIDER _____

The above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me or my eligible dependents on the date(s) indicated. I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

RESET FORM

PRINT FORM