H R SUPPORT & CONSULTING SERVICES, INC.
FLEX ADMINISTRATION

Phone: 207-655-5396

Website: www.hrscflex.com

REIMBURSEMENT REQUEST FORM

(Instructions: Please Print Clearly, Complete items 1 and 4, and 2 and/or 3 as applicable and return as instructed below)

1. EMPLOYEE INFORMATION

Employer:		**SS#: (Last 4 digits only)** 000-00-
Employee Name:		**Home Phone:**
Home Address: ☐ Check here if new address.		**Work Phone**:
City:	**State**:	**Zip Code**:

2. MEDICAL CARE REIMBURSEMENT ACCOUNT

Copies of all bills/statements/E.O.B. must be attached which provide name and address of service provider, type of service, service date, and amount. Cancelled checks and/or Credit Card receipts are not acceptable.

Amount	Provider's Name:	Service for: (Please circle one)	Date Service Received
		Self Spouse Child Other	
		Self Spouse Child Other	
		Self Spouse Child Other	
		Self Spouse Child Other	
		Self Spouse Child Other	

Total _________

3. DEPENDENT CARE REIMBURSEMENT ACCOUNT

Please attach receipt showing signature & tax id or have provider sign and enter tax identification number below.

Amount	Provider's Name:	Services For: (Specify)	Dates of Service
			TO
			TO
			TO
			TO
			TO

X ______________________________ ______________________________ ______________

Signature of Dependent Care Provider **Tax I.D./S.S.#** **Date**

4. EMPLOYEE CERTIFICATION

I request reimbursement from my Reimbursement Account(s) as itemized above. These expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and that reimbursed expenses cannot be claimed as credits or deductions on my personal income tax. I understand I am ineligible to participate in my employer's Medical Reimbursement Account if I participate in a Health Savings Account (HAS). Requests for reimbursement from the Dependent Care Reimbursement Account must be for the primary purpose of assuring the dependent's well-being and protection and the care is necessary so that I (and my spouse if married) can work or attend school full time.

Employee Signature ____ **Dated** ____________________

Send Your Claims To:
E-MAIL: INFORMATION@HRSCFLEX.COM
H R Support & Consulting Services, Inc.
Attn: Flex Administration
159 Watkins Shores Road
Casco, ME 04015-4309
FAX: (207) 655-6636