H R SUPPORT & CONSULTING SERVICES, INC.
FLEX ADMINISTRATION
Toll Free: 1-866-655-5397/website: wwww.hrcsflex.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):_____

Employee Name:_____ Home Phone:_____

Home Address ☐ check here if new address:_____

City:_____ State:_____ Zip:_____ Work Phone:_____

2. MEDICAL CARE REIMBURSEMENT ACCOUNT

Copies of all bills must be attached which provide name and address of service provider, type of service, and date and amount of service. Cancelled checks are not acceptable receipts.

Amount	Payment Made To:	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	Payment Made To:	Services For (specify)	Dates of Service
		self spouse child other	
		self spouse child other	
		self spouse child other	
		self spouse child other	
		self spouse child other	

TOTAL_____

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 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 to:
H R Support & Consulting Services, Inc.
Attn: Flex Administration
159 Watkins Shores Road
Casco, ME 04015-4309
Fax (207) 655-6636