

Flexible Spending Account Request for Reimbursement

Saginaw Valley State University

Instructions: Please type or print the required information.

Attach the appropriate invoices. Sign and return to SVSU Controller's Office, South Campus Complex A.

Employee Name	Employee Identification Number	Phone Number

HEALTH CARE REIMBURSEMENT INFORMATION

Attach original receipts, not copies. Receipt must list patient, provider of service, service date and amount. Only expenses for employee, spouse or dependent are eligible for reimbursement. Canceled checks, credit card receipts or bills showing only a payment or previous balance are not acceptable. Attach flex spending account reimbursement request supplement form if additional space is needed.

Patient	Relationship	Provider of Service	Date(s) of Service	Total Amount of Expense	Less Amount Paid by Insurance	Amount to be Reimbursed
Subtotal of Health Care Expenses						

WORK-RELATED DEPENDENT CARE REIMBURSEMENT INFORMATION

Attach receipt listing name of child or dependent, provider name, dates of service and amount. Canceled checks, credit card receipts or bills showing only a payment or previous balance are not acceptable.

Dependent	Age ^A	Relationship ^A	Provider Name ^B	Provider ID No.	Date(s) of Service	Amount
Subtotal of Dependent Care Expenses						

A A qualifying person is your dependent who is under age 13, your spouse who is physically or mentally not able to care for himself or herself and lived with you more than half the year or a person who was physically or mentally not able to care for himself or herself, lived with you and was a dependent (see IRS rules for exception).

B No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes or is your child or stepchild and is under age 19.

TOTAL REIMBURSEMENT SUMMARY AND SIGNATURE

Subtotal of Health Care Expenses	\$ _____
Subtotal of Dependent Care Expenses	\$ _____
Total Expenses	<u><u>\$ _____</u></u>

I request payment from my Flexible Spending Account for the expenses itemized above. I certify that I have not been reimbursed under this Plan or from any other source for these expenses. I also certify that the total dependent care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that all submitted expenses are eligible health care and dependent care expenses based on Internal Revenue Service guidelines. I understand that expenses reimbursed under this plan cannot be claimed as deductions or credits on my personal income tax return.

Employee Signature _____
Date

OFFICE USE ONLY The expenses itemized above have been reviewed and processed for payment.

ABA 882-04-07

Signed – Plan Administrator _____
Date Processed