YourFlex

REQUEST FOR REIMBURSEMENT

Instructions

1. **Complete all sections below. Sign and date.**
2. **Attach a copy of an itemized bill, receipt or explanation of benefits to the back of this form. These must show service date, charge amount, and describe the nature of the expense. For dependent care expenses include the provider's Federal Tax ID Number or Social Security Number. Cancelled checks, charge receipts and balance forward bills are not considered adequate. Please enter one expense on each line.**
3. **Mail or fax these items to the address or fax number noted below. Be sure to keep a copy for yourself.**

Check if Address Has Changed ☐

Employee Information

Name:	Last 4 digits of SSN: XXX-XX-_____
Street Address:	Employer:
City, State & Zip:	Work Phone #:

Dependent Care Reimbursement Account

Provider Name	Taxpayer ID or Social Security No.	Date Expenses Incurred From	Date Expenses Incurred To	Relationship of Dependent	Age	Reimbursable Expense Amount
				TOTAL:		

Medical Reimbursement Account

Provider Name/Expense Description	Date Expenses Incurred From	Date Expenses Incurred To	If Dependent, Give Relationship		Reimbursable Expense Amount
 Check this column if your MySource Card was used for this Expense			**TOTAL:**		

Employee Certification

I request reimbursement from my Flexible Spending Account(s) for the expenses itemized above. I certify these expenses were paid by me for the benefit of myself or my dependants. They are not eligible for reimbursement from any other source, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Employee Signature: _____ **Date:** _____