

# TOOELE CITY CORP.

**FLEXIBLE BENEFIT PLAN**

**REIMBURSEMENT REQUEST FORM**

Name _____		Social Security Number _____			
Mailing Address _____					
Street	City	State	Zip Code	Phone	

*Instructions:* Please complete this form to receive reimbursement from the Tooele City Corp. Flexible Benefit Plan. The form must be signed and dated. Attach original receipts, bills, statements, as supporting documents. Documentation will not be returned. Eligible expenses are those expenses incurred by you, your spouse, or your eligible dependents and qualify as eligible deductions by the IRS, and are not or cannot be reimbursed from any other source. Expenses may be incurred up to 2 1/2 months after the last day of the plan year. Reimbursed expenses cannot be taken as a deduction on income tax returns. **The minimum check amount is \$30.00. Claims will be held until \$30 minimum is reached.**

<b>Health Care Expenses</b>					
The information on the documents must include the following:					
Date(s) of service		Type of expense (i.e., eye exam)			
Amount of the expense			Name of the service Provider		
Patient	Relationship	Dates of Services		Description	Amount
		From	To		
<b>TOTAL</b>					

<b>Day Care Expenses</b>				
Please provide the following information: A statement from the day care provider listing:				
Date(s) of service		Charges	Provider's signature	
Dependent	Relationship	Dates of Services		Amount
		From	To	
<b>TOTAL</b>				

<b>Verification of Day Care Expenses</b>	
Provider Name _____	Tax ID # _____
Provider Address _____	

I request payment from my reimbursement account for the above expenses. To the best of my knowledge, these expenses are eligible under the plan. I understand that these expenses must qualify under applicable sections of the Internal Revenue Code and certify that they are not eligible for reimbursement from any other source.

Signature \_\_\_\_\_ Date \_\_\_\_\_