

# 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 \_\_\_\_\_