SECTION 125 FLEXIBLE BENEFITS PLAN
REQUEST FOR REIMBURSEMENT

NAME: Last, First MI   PHONE: (Area Code) + Number

ADDRESS: Street City State Zip

Directions for using this Reimbursement Form

For each of the accounts in which you are submitting claims, please complete the appropriate section and **then attach the documentation for the expenses listed** (minimum of $50 unless it is the final request for the Plan Year).

MEDICAL EXPENSE REIMBURSEMENT – Attach receipts. If the expense is covered under any Medical/Dental plan, attach a copy of the Explanation of Benefits received from the carrier showing their determination of the claim.

Date of Service MM/DD/YY	Patient Name	Name of Provider	Description of Service	Claim Amount
				$
				$
				$
				$
				$
				$

Total: $____________________

DEPENDENT CARE REIMBURSEMENT – attach receipts

Date of Service From:---To:---	Dependent Name	Dependent Care Provider Name	Claim Amount
			$
			$
			$
			$

Total: $____________________

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expense for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents for medical reimbursement), were not reimbursed by any other source, and to the best of my knowledge and belief are eligible for reimbursement under my reimbursement plans. I will not use (nor will anyone else use) the expense reimbursed through this account as deductions or credits toward federal income tax liability. **Any person who knowingly & with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.**

Signature: ____   Date: ____________________

Plainville Community Schools
Municipal Center, One Central Square, Plainville, CT 06062
(860) 793-3210 x 213
Fax: (860) 747-6790

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