



REQUEST FOR FLEX REIMBURSEMENT

**Internal Use Only**

Company ID# \_\_\_\_\_ Date Received: \_\_\_\_\_ Initials: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security: \_\_\_\_\_

Employer: \_\_\_\_\_

**DEPENDENT CARE – List each receipt separately (use additional forms if necessary)**

(A) Name of Dependent	Age	(B) Provider Name	(C) Date(s) of Service	(D) Requested Amount of Reimbursement	Internal Use Only

Please attach a receipt or itemized bill providing evidence of (A), (B), (C) and (D). Canceled checks, credit card receipts, and bills showing only a payment, previous balance, or balance due are not acceptable documents.

**UNREIMBURSED MEDICAL – List each receipt separately (Use additional forms if necessary)**

(A) Patient's Name	(B) Provider Name	(C) Description of Service	(D) Date(s) of Service	(E) Requested Amount of Reimbursement	Internal Use Only

Please attach a third-party receipt, itemized bill, or Explanation of Benefits (EOB) providing evidence of (A), (B), (C), (D) and (E). Canceled checks, credit card receipts, and bills showing only a payment, previous balance, or balance due are not acceptable documents.

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are eligible medical or dependent care expenses that I or my dependents have incurred. I understand that medical expenses must qualify as deductible expenses for federal income tax purpose, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that dependent care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return. I hereby authorize the Plan and its service provider (AFLAC and DynamicHR), their respective agents, employees, sub-contractors and assigns to use the information provided above to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose any and all such information as is reasonably required for such purpose. I further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud. I hereby expressly waive and release any claims to the use, disclosure, or release of such information so long as the information is used in furtherance of administrating the Plan, including the processing or evaluating of my claim for benefits under the Plan, or detecting fraud. This authorization does not and is not intended to in any way limit any right the Plan, AFLAC or DynamicHR, or their respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date