BAY MILLS COMMUNITY COLLEGE
FLEXIBLE SPENDING ACCOUNT
REQUEST FOR REIMBURSEMENT

Employee Name:_____ **Social Security Number:**_____

Employee Address:_____

Dependent/Child Care **LIST EACH RECEIPT SEPARATELY, (Use additional forms if necessary.)**

(A) Name of Dependent	Age	(B) Provider Name	Provider ID No.	(C) Date(s) Service Provided	(D) Requested Amount of Reimbursement

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Canceled checks or bills showing only a payment or previous balance are not acceptable.

Provider's Certification/Verification

I certify that the above-described dependent care expenses were incurred by the employee named above.

Business/Provider Signature Address Date

Unreimbursed Medical **LIST EACH RECEIPT SEPARATELY, (Use additional forms if necessary.)**

(A) Patient Name	(B) Provider Name	(C) Description of Service	(D) Date(s) Service Provided	(E) Requested Amount of Reimbursement

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

Provider's Certification/Verification

I certify that the above-described unreimbursed medical expenses were incurred by the employee named above.

Business/Provider Signature Address Date

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 purposes, 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.

Date:_____Employee Signature:_____