


## Request for Reimbursement

<b>1. Employee Information</b> – Complete all sections.				Social Security Number (optional)	
<input type="checkbox"/> <i>Check box if new address</i>	Name			Employer <b>Cornell College #32800</b>	
Home Address			E-Mail Address		
City		State	Zip (9 digit if known)	Daytime Phone Number	

<p style="color: red; font-weight: bold; font-size: 1.2em;">Sign Here</p> <p style="color: red; font-weight: bold;">Employee Signature Required</p> 	<p><b>Employee Certification</b></p> <p>I request reimbursement from the following reimbursement account(s) for the expenses itemized below. I certify that the expenses for which reimbursement is requested under the reimbursement account(s) were for services received either by myself or my eligible dependent(s). I also certify that I or my eligible dependent(s) have received the services described on the dates indicated, and these are my out-of-pocket expenses that qualify as valid expenses under the plan and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan covering health benefits. I also certify that these expenses are to alleviate a medical condition and not just merely beneficial to my general health. I understand that if I, my spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a Limited Purpose Medical Reimbursement Account which can only pay qualified expenses related to vision and dental care. I further understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. To the best of my knowledge and belief, my statements on this form are complete and true.</p>		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">Signature</td> <td style="padding: 5px;">Date / /</td> </tr> </table>		Signature	Date / /
Signature	Date / /		

**2. Medical Reimbursement** – Attach an Explanation of Benefits, an itemized receipt, or other 3<sup>rd</sup> party verification (8 ½ x 11 paper photocopies) of each expense claimed, indicating the service(s) provided, date(s) of service, and charges. **Balance forward statements, cancelled checks and credit card receipts are NOT acceptable documentation for reimbursement.**

Person Receiving Care	Relationship	Date Expense Incurred	Description of Expense	Total Expense	Amount Paid or Payable Under Another Plan or Source	Reimbursement Requested
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
<b>Total Reimbursement Requested</b>						\$

**3. Dependent Care Reimbursement (day care expenses)** – Obtain care provider’s signature in the space below *or* attach an itemized receipt or other 3<sup>rd</sup> party verification (8 ½ x 11 paper photocopies) of each expense claimed, indicating date(s) of care and total charges. **Balance forward statements, cancelled checks and credit card receipts are NOT acceptable documentation for reimbursement. IRS regulations allow payment for services that have already been provided, not for services to be provided in the future.**

Dependent Receiving Care	Relationship	Age	Date(s) of Care	Care Provider Name and Social Security # or Federal Tax I.D. #	Reimbursement Requested
<b>Total Reimbursement Requested</b>					\$

I certify that the expenses shown are valid.  
 Signature of Dependent Care Provider \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

<p><b>4. Mail or Fax your claim form, with documentation, to:</b></p> <p>Flexible Benefits Department    Phone: (800) 941-4404        First Administrators, Inc.      Fax: (712) 279-8479        PO Box 9900                          Email: flex@firstadministrators.com        Sioux City, IA 51102-0479</p>	<p><b>Plan Administrator Use Only</b></p> <p>Notes: _____</p> <p>Case _____ Cert _____</p>
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Did you remember to:  Sign and date your claim form     Read the account guidelines on the back  
 Provide proper documentation                                     Retain original documents for your records as we do not return documents

FAILURE TO COMPLETE ALL APPROPRIATE SECTIONS OF THE CLAIM FORM OR SUBMIT LEGIBLE ITEMIZED RECEIPTS FROM YOUR PROVIDER MAY DELAY THE PROCESSING OF YOUR CLAIM(S).