

Flexible Spending Plan Reimbursement Request

(Minimum Distribution \$25.00)

Please type or print clearly. Completed forms must be delivered intact with attached appropriate documentation to Local Office Benefits Administrator by the end of the month to be reimbursed the following month.

Employee Name _____

Employee Social Security Number XXX-XX- _____ Location _____

Expenses incurred for: _____ Relationship _____

Date incurred	Name of provider or transportation/lodging	Proof of Expense			Amount of Charges
		Circle one and attach copy of documentation Must include address of provider			
1. _____	_____	Insurance Explanation Of Benefits	Provider Statement	Provider Receipt	Transportation Expense Worksheet \$ _____
2. _____	_____	Insurance Explanation Of Benefits	Provider Statement	Provider Receipt	Transportation Expense Worksheet \$ _____
3. _____	_____	Insurance Explanation Of Benefits	Provider Statement	Provider Receipt	Transportation Expense Worksheet \$ _____
4. _____	_____	Insurance Explanation Of Benefits	Provider Statement	Provider Receipt	Transportation Expense Worksheet \$ _____

Expenses incurred for: _____ Relationship _____

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3. _____	_____	Insurance Explanation Of Benefits	Provider Statement	Provider Receipt	Transportation Expense Worksheet \$ _____
4. _____	_____	Insurance Explanation Of Benefits	Provider Statement	Provider Receipt	Transportation Expense Worksheet \$ _____

Total expense on this request \$ _____

I certify that the amounts herein requested for reimbursement have been actually incurred as qualified expenses and have not, cannot and will not be reimbursed from any insurance or other benefit plan, be deducted on my income tax return nor were they previously submitted for reimbursement under this plan.

Employee Signature _____ Date _____

Transportation and Lodging Expense Worksheet

(See below for eligibility and limits.)

Employee Name _____ Social Security Number XXX-XX-_____

Office Location _____

A. Transportation Expenses

	<u>Date</u> <u>Incurred</u>	<u>For Whom</u>	<u>Amount of</u> <u>Charge</u>
1. Non-Auto Transportation			
Bus _____	_____	_____	\$ _____
Train _____	_____	_____	\$ _____
Taxi _____	_____	_____	\$ _____
Airplane _____	_____	_____	\$ _____
Ambulance _____	_____	_____	\$ _____
2. Personal Auto Use			
Actual expense (gas and oil) <u>OR</u>	_____	_____	\$ _____
Mileage Allowance (\$.18 per mile)	_____	_____	\$ _____
<u>PLUS</u> Parking Fee	_____	_____	\$ _____
<u>PLUS</u> Tolls	_____	_____	\$ _____

B. Lodging Expense

Meals _____			\$ _____
Lodging _____			\$ _____

Total transportation/lodging expenses (attach dated receipts where applicable) \$ _____

Employee Signature _____ Date _____

Transportation: YOU MAY INCLUDE as medical expenses amounts paid for transportation primarily for and essential to medical care.

- Bus, taxi, train, plane fare or ambulance service
- Actual car expenses such as gas and oil. Do not include expenses for general repair, maintenance, depreciation and insurance or
- Cost of \$.18 per mile for each mile your car is used for medical reasons and cost of parking fees and cost of tolls
- Parent's transportation expenses if a parent must go with a child who needs medical care
- Transportation expenses of a nurse or other person who can give injections, medications or other treatment required by a patient who is traveling to get medical care and is unable to travel alone
- Transportation expenses for regular visits to see a mentally ill dependent if these visits are recommended as part of treatment

DO NOT INCLUDE

- Transportation expenses to and from work, even if your condition requires an unusual means of transportation
- Transportation expenses if, for non-medical reasons only, you choose to travel to another city such as a resort area for an operation or other medical care prescribed by your doctor.

Lodging: YOU MAY INCLUDE as medical expenses the cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive medical care. YOU MAY INCLUDE as medical expenses the cost of lodging (not provided in a hospital or similar institution) while away from home if:

- The lodging is primarily for and essential to medical care
- Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to or equivalent of a licensed hospital
- The lodging is not lavish or extravagant under the circumstances and
- There is no significant element of personal pleasure, recreation or vacation in travel away from home.

The amount you include in medical expenses may not exceed \$50.00 for each night for each person. Lodging is eligible for a person for whom transportation expenses are eligible because that person is traveling with the person receiving the medical care, for example: a parent traveling with a sick child. In that case, up to \$100.00 per night is eligible for lodging.