

FLEXIBLE BENEFITS PLAN CLAIM FORM

WASHINGTON & LEE UNIVERSITY

SSN: _____/_____/_____

Participant's Name: _____
Last First

Email Address: _____

The undersigned participant in the Plan requests reimbursement in the amount(s) shown below.

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as signing below to verify that the claim is not being reimbursed by an Insurance Company or another Flexible Benefits Plan. Also, you will not be entitled to claim this expense as a tax deduction.

MEDICAL CARE EXPENSE REIMBURSEMENT

of receipts attached _____ \$ _____ reimbursement requested

DAYCARE ACCOUNT EXPENSE REIMBURSEMENT

Dependent's Name: _____ Service provider: _____

Service Provider's Signature: _____

Period Covered: _____/_____/_____ through _____/_____/_____ Amount: \$ _____

Tax ID or SSN of service provider: _____

NOTE: The total amount claimed under the Dependent Care Flexible Spending Account for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary of your spouse. (If your spouse is either a full time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent, and \$500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY

The undersigned participant in the Health Flexible Spending Account certifies that all expenses for which reimbursement or payment is under the a Cafeteria Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Employee's signature

Date _____

Innovative Employee Benefits, Inc.

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