



**WRIGHT STATE
UNIVERSITY**

**FLEXIBLE SPENDING ACCOUNT
REQUEST FOR REIMBURSEMENT**

EMPLOYEE INFORMATION *(Please Print)*

Check here if address has changed

Name: _____

Email: _____

Address: _____

Social Security No.: _____

City, State, Zip: _____

Home Phone: _____

UNREIMBURSED HEALTH CARE EXPENSES *(Attach Supporting Documentation)*

Receipt must include the provider's name, address, dates of service, service provided and amount.

Person for Whom Expense was Incurred	Date Of Service	Name of Service Provider	Description of Services	Amount
TOTAL UNREIMBURSED HEALTH CARE EXPENSES				

DEPENDENT CARE EXPENSES *(Attach Supporting Documentation)*

Receipt must include the provider's name, address, Fed. I.D.#, dates of service and amount.

Name of Dependents and Ages	Service Date		Name, Address and Social Security Number or Tax Identification Number of Service Provider	Amount
	From	To		
TOTAL DEPENDENT CARE EXPENSES *				

I certify that I have provided dependent care as noted above. I have received \$ _____ as payment for the services I rendered on the dates listed above.

Provider Social Security # or Taxpayer ID #

Signature of Dependent Care Provider

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated. The expenses were incurred while I was covered under the Flexible Spending Account(s). I have submitted any health care expenses covered by other health care plan(s) to those plans, but payment has been denied in full or in part, as shown on the attached form(s). Receipts from my service provider(s) for all expenses are attached to this voucher. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Signature

Date

Mail To: MyCafeteriaPlan.com 432 East Pearl Street, Miamisburg, OH 45342

Phone: 937-865-6500 Toll-free: 800-865-6543 Fax: 937-865-6502 Email: info@mycafeteriaplan.com

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