## REQUEST FOR REIMBURSEMENT FROM EMPLOYEE FLEXIBLE SPENDING ACCOUNT

Please complete this form and attach appropriate receipts before submitting for reimbursement.

EMPLOYER: **Archdiocese of Louisville** DATE: _____

NAME: _____ SS# : _____

ADDRESS: _____ ☐ check if new address

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____ PHONE: _____

PLAN YEAR: ☐ * * * * * Please fill out separate forms for separate Plan Years. * * * * *

**MEDICAL EXPENSE** *The Health Care Reform Act requires that all OTC medication claims be substantiated with a Physician's Rx.*

| SERVICE DATE | PROVIDER | DESCRIPTION | AMOUNT |
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| | | **TOTAL EXPENSE** | |

**DAY CARE EXPENSE** *Care performed by individuals can be substantiated with a canceled check if the provider's SSN is attached.*

| SERVICE DATE | PROVIDER | Tax ID # | AMOUNT |
|---|---|---|---|
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| | | **TOTAL EXPENSE** | |

To the best of my knowledge, the information provided in this request for reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible plan participants. **I acknowledge that I have a valid Rx for all OTC medications claimed.** I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an Income Tax deduction. I authorize my FSA amount to be reduced by the amount requested up to the total eligible for the Plan Year.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

For proper administration, this form and supporting documentation should be sent to:

A I M
Administrative
Information
Management

ADMINISTRATIVE INFORMATION MANAGEMENT, INC.
10353 Linn Station Rd
Louisville KY 40223
FAX: (502) 426-6569

**** * SAVE PAPER - USE THIS CLAIM FORM AS YOUR COVER PAGE. * ****