

FLEXIBLE SPENDING ACCOUNTS REIMBURSEMENT REQUEST FORM

Employee Name _____
 SS# (REQUIRED) _____
 Employer Name SIMPSON COLLEGE
 Mail claim form to: Alliance Benefit Group, North Central States
 P.O. Box 1226
 Albert Lea, MN 56007
 FAX CLAIMS TO: 507-373-2409

PLEASE BE SURE TO ATTACH A THIRD PARTY STATEMENT OR EXPLANATION OF BENEFITS FROM INSURANCE FOR MEDICAL REIMBURSEMENT CLAIMS. FAILURE TO DO SO WILL RESULT IN CLAIMS DENIAL. SEE #3 ON BACK OF FORM.

SECTION ONE Medical Reimbursement (Medical, Dental, Vision)

(1) Line	(2) Provider of Service (Name of doctor, dentist, druggist, etc.)	(3) Service for: (self, spouse, dependents)	(4) Dates of Service (MO/DAY/YR)	(5) Amt of Expense Claimed	(6) Provider of Service (Name of doctor, dentist, druggist, etc.)	(7) Service for: (self, spouse, dependents)	(8) Dates of Service (MO/DAY/YR)	(9) Amt of Expense Claimed
1				\$				\$
2				\$				\$
3				\$				\$
4				\$				\$
5				\$				\$
6				\$				\$
7				\$				\$
8				\$				\$
9				\$				\$
10				\$				\$
11				\$				\$
12				\$				\$
Subtotal								Total Medical Claim

SECTION TWO Dependent Care Reimbursement

CERTIFICATION: If box 8 is completed, it may be used instead of an invoice with respect to dependent care expenses on lines 1-5 below(8)

(1) Line	(2) Dependent Care Provider	(3) Tax Identification Number of Provider (e.g. Social Security #)	(4) Person Receiving Service (dependent's name)	(5) Age of Dependent	(6) Dates of Service (MO/DAY/YR)	(7) Amt of Expense Claimed	(8) Certification of Provider Signature and Expense Amount
1						\$	/ \$
2						\$	/ \$
3						\$	/ \$
4						\$	/ \$
5						\$	/ \$
Total Dependent Care Claim							Total Medical Claim

I certify that these expenses are not eligible for reimbursement under any other plan, and comply with the requirements of this Plan. I have not and will not claim these expenses for tax credit or deduction purposes on my income tax return. With respect to any dependent care expenses claimed above, I certify that, to the extent required by federal law, I will file the designated form with the IRS by April 15 of the year after the expenses were incurred indicating the name, address, and taxpayer identification number of the provider of these dependent care services.