Flexible Spending Account/125-Cafeteria Plan
Reimbursement Request Form

Employer **DIVINE WORD COLLEGE**

Employee Name: Last _____First _____ MI _____

Home Address: _____City _____ State____ Zip ____

Medical Reimbursement Expense

Unreimbursed Medical Expense Request Total $ _____
(Attach copy of insurance or receipts)

Dependent Care Reimbursement Expense

Day Care Expense Request Total $ _____

Name of Dependent Care Provider _____

Address of Dependent Care _____

- Tax ID Number of Dependent Care Provider _____
- Period of Day Care: From _____ to _____
- Day Care Provider Signature: _____ Date _____
  (Receipt not required if completed and signed by day care provider)

I hereby certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses. I also understand that Divine Word College, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement.

Plan Participant's Signature _____ Date _____

Reimbursement Guidelines:

1. Total requests must total $25 or more.
2. Reimbursement request expense is for an IRS eligible expense and was incurred during flex plan year.
3. The reimbursement request has not been previously reimbursed and is not eligible for reimbursement from insurance.
4. Please attach a copy of receipts or bills or insurance notifications of benefits to document each reimbursement request.
5. Reimbursement requests must include the following:
   * Name of Provider * Type of service / supply provided
   * Date of service/purchase * Charge for each service/supply
6. Please attach a copy of receipts for dependent care which meets the age requirements of under age 13, or for a person of any age you claim as a dependent on your federal income tax return and who is mentally or physically incapable of caring for himself or herself.

DO NOT ATTACH ORIGINALS OF BILLS OR INSURANCE STATEMENTS.
KEEP ORIGINALS FOR YOUR RECORDS.