EXPENSE REIMBURSEMENT VOUCHER

IRS Section 125 Flexible Benefit Plan

Name of Employee (Last, First, M.I.) Daytime Phone Number

Address ***(Check box if new address)*** Social Security Number (Required)

City & State Zip Code Agency Name and Number

Only include expenses that are not reimbursable under your insurance plans or any other source for you or your qualified dependents.

Date of Services	Name of Person for Whom Expense was incurred and Type of Expense	Amount of Health Care	Amount of Dependent Care
	Total Requested		

DENTAL and MEDICAL EXPENSES: For each expense listed above that is or may be covered under an insurance plan, submit your bills to the insurance company(ies) and then ***submit the insurance company statement of benefits*** showing the amount of expenses not covered by insurance ***with this form.*** For other expenses attach an itemized statement. For prescription drugs, attach the pharmacy statement or label – a cash register tape is not acceptable. Keep a copy of all documentation for your records. **For covered over-the-counter items a cash register tape with the name of the drug imprinted by the store register is required** (List of approved over-the-counter items on our website at www.ebc.state.ok.us).

DEPENDENT CARE EXPENSES: For each dependent care expense listed above, ***attach a third party statement or*** complete the Dependent Care Provider Acknowledgement***, provider signature is required***. The qualified dependent who spends at least eight hours a day in your home must be age 12 or under; or any other qualified dependent person, who is physically or mentally incapable of self care (such as a disabled parent or older child) regardless of age. A doctor's statement of disability is required. Qualified expenses are for care only. Educational expenses, registration and activity fees are not reimbursable.

I HEREBY CERTIFY that the expense(s) shown has(have) actually been incurred as an eligible plan expense(s) during the eligible date above for myself, my spouse, or my qualified dependent; and that this expense(s) has(have) not been, and I will not seek to be paid or reimbursed by an insurance company or from any other source, be deducted or used to calculate a tax credit on any tax return or has previously been submitted for reimbursement under this or any other plan. If daycare, I certify the qualified dependent spends eight hours in my home daily, had the same principal place of abode for more than half of the year, and is under age 13, the provider is not also a qualified dependent and complies with federal, state, and local laws. **I understand that any amounts not used for qualified expenses by the end of the Plan Year will be forfeited to the plan per IRS Regulations.**

SIGNATURE OF EMPLOYEE REQUIRED Date Signed

Note: Medical expenses that have been reimbursed under this Plan are not deductible by the employee for Federal Income Tax purposes. In addition, dependent care (day care) expenses reimbursed under this Plan may not be used for dependent care tax credit purposes by the employee.

Mail to: **Employees Benefits Council**
Flexible Spending Accounts
PO Box 24087
Oklahoma City, OK 73124-0087
(405) 232-1190 x301 in OKC or 1-800-219-8115 x301 in Oklahoma

Claim must be received or US Postmarked by March 31.

DEPENDENT CARE (DAY CARE) PROVIDER ACKNOWLEDGMENT

(COMPLETE EXPENSE REIMBURSEMENT VOUCHER AND THIS FORM)

The Dependent Care (Day Care) Provider acknowledges that it has billed or received $ _____ from _____(Employee's Name/Participant) for dependent care services rendered for the period of _____ through _____ for the following tax-eligible dependents.

Dependent Name:	**Age** (12 or under):
_____	_____
_____	_____
_____	_____

Provider Name _____

ADDRESS OF PROVIDER: _____

_____

_____ is the Tax I.D. Number of Dependent Care Center or Social Security Number of Individual Provider.

_____ _____

PROVIDER SIGNATURE Date Signed

<u>Provider Signature on this form or third party receipt with the above information is required.</u>
Keep a copy of this form for your records.