REQUEST FOR REIMBURSEMENT FROM EMPLOYEE FLEXIBLE SPENDING ACCOUNT

Please complete the applicable space on this form and attach appropriate bills/receipts before submitting for reimbursement. Dependent Care Services performed by individuals can use a cancelled check if the individual's social security number is attached.individual's social security number is attached.

* * * * * * * * Please fill out separate forms for separate plan years. * * * * * * * *

EMPLOYER: **Archdiocese of Louisville** Subgroup # Date:

NAME: SS#:

MAILING ADDRESS:

CITY: STATE: ZIP:

New Address ☐ **Plan Year** ☐

MEDICAL/HEALTH EXPENSE - FMED - FOR SELF AND DEPENDENTS

DATE OCCURRED	PAYMENT TO	DESCRIPTION	AMOUNT
		TOTAL EXPENSE	

DAY CARE EXPENSE

DATE OCCURRED	PROVIDER	TAX ID#	AMOUNT
		TOTAL EXPENSE	

To the best of my knowledge and belief, my statements of this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and eligible plan participants. 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 flexible spending account to be reduced by the amount requested up to the total elected for the plan year.

EMPLOYEE SIGNATURE: _____ Date: _____

NOTE: THIS FORM SHOULD BE SENT TO AIM FOR PROPER ADMINISTRATION

ADMINISTRATIVE INFORMATION MANAGEMENT, INC.
10353 LINN STATION ROAD
LOUISVILLE, KY 40223