

**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 canceled check if the individual's social security 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
<b>TOTAL EXPENSE</b>			<input type="text"/>

**DAY CARE EXPENSE**

DATE OCCURRED	PROVIDER	Tax ID #	AMOUNT
<b>TOTAL EXPENSE</b>			<input type="text"/>

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year and for 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'S SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

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

ADMINISTRATIVE INFORMATION MANAGEMENT, INC.  
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 FAX: (502) 426-6569