

BEAL CITY PUBLIC SCHOOLS  
FLEXIBLE BENEFITS PLAN  
REQUEST FOR REIMBURSEMENT

Please complete the applicable spaces on this form, and attach appropriate paid bills or receipts before submitting for reimbursement. Cancelled checks are only acceptable in relationship to childcare expenses. The name, address and social security or taxpayer I.D. number of your childcare provide must also be included. Additionally, a copy of the social security card or a signed W-10 must be on file for the provider. Specific service and dates, name of provider and dollar amounts must be provided for all medical reimbursement claims. All claim submissions must also reflect insurance reimbursements.

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last Four Digits of Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

<u>Type of Expense</u>	<u>Date Incurred</u>	<u>Provider</u>	<u>Amount</u>
_____ Medical	_____	_____	\$ _____
	_____	_____	\$ _____
_____ Child Care	_____	_____	\$ _____
	_____	_____	\$ _____

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 deduction. I authorize my flexible spending account be reduced by the amount requested.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send Claims or Fax to: Benefit Consulting Group, Inc.  
115 ½ S. University  
Mt. Pleasant, MI 48858  
Phone: (989) 772-4969  
Fax: (989) 772-3539