Benefit Consulting Group, Inc.

REQUEST FOR REIMBURSEMENT FORM

Name: ____ **Social Security # (last four digits):** _____________

Home Address: _______________________________**City:** _______________ **State:** _______ **Zip Code:** _________

Employer Name: ____ **Phone Number:** ___________________________

THIS FORM MAY BE USED FOR EITHER THE HEALTH CARE REIMBURSEMENT ACCOUNT AND/OR DEPENDENT CARE REIMBURSEMENT ACCOUNT FOR REQUESTS FOR REIMBURSEMENT.

HEALTH CARE REIMBURSENT ACCOUNT

MEDICAL: $ ________________________

Note: Receipt(s) must be included for medical expenditures. Claims will not be processed without receipt(s).

DEPENDENT DAYCARE REIMBURSEMENT ACCOUNT

Name of Dependent(s): ____

Relationship: ____

Name of Provider ______________________________ **Provider's Taxpayer ID or SSN (Required)** _______________

Dates Daycare Provided: From ______________________________ **To** ____________________________________

DEPENDENT DAYCARE: $ ____________________________

Note: Daycare receipt(s) must also list dates daycare was provided. Claims will not be processed if this information is missing.

I request reimbursement from my account. I certify that the information provided is true and correct, that these expenses are not, and will not be, covered by any insurance program, and that I have not, or will not, claim these expenses as income tax deductions on my income tax return, and that the expenses submitted qualify as required. I also understand that the Internal Revenue Service may require proof that these are eligible expenses, and that I am responsible for providing such proof.

Total Amount Submitted: $_________________________________

Signature (Required): ____ **Date:** _____________________________

Send this completed form, along with receipts, to Benefit Consulting Group, Inc., PO Box 526, Mt. Pleasant, MI 48804-0526, or fax to (989) 772-3539.

For Questions Call: (989) 772-4969