General Agency Company

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 General Agency Company, 525 East Broadway, Mt Pleasant, MI 48858, fax to (989) 772-1855 or email to cwild@ga-ins.com.

For Questions Call: (989) 773-6981