

FLEXIBLE SPENDING ACCOUNT
REQUEST FOR REIMBURSEMENT

Huntington University

EMPLOYEE NAME: _____ S.S. # _____

ADDRESS: _____ INDICATE IF NEW ADDRESS

REQUEST TYPE: MEDICAL EXPENSES (IRC 106)
 DEPENDENT CARE EXPENSES (IRC 129)

* INITIAL CLAIM FOR DEPENDENT CARE MUST INCLUDE PROVIDER OF DEPENDENT CARE SOCIAL SECURITY NUMBER OR FEDERAL I.D. NUMBER:

S.S. # _____ OR FEDERAL I.D. # _____

DESCRIPTION OF EXPENSE - <i>Proof of Payment Attached</i>	AMOUNT OF EXPENSE
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
	TOTAL \$ _____

I affirm that the above request for reimbursement are expenses recognized by the Internal Revenue Code as tax deductible expenses under section 125 "Cafeteria Plans" and assume all responsibility for taxes or penalties arising out of any disallowed deduction.

SIGNATURE: _____

DATE: _____

MAIL THIS CLAIM FORM WITH ATTACHED PROOF OF PAYMENT TO:



UNIFIED GROUP
SERVICES, INC.

P.O. Box 10
Pendleton, IN 46064

Phone : (800) 291-5837
Fax: (765) 608-6689