

MISCELLANEOUS REIMBURSEMENT REQUEST FORM



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|--|---|--|
| <input type="checkbox"/> Health Club | <input type="checkbox"/> MEA Dues | <input type="checkbox"/> PERS Long Term Care |
| <input type="checkbox"/> Cultural Arts | <input type="checkbox"/> Professional Coaching | <input type="checkbox"/> SDI Reimbursement |
| <input type="checkbox"/> Excess Tuition | <input type="checkbox"/> Retirement Buy Back Plan | <input type="checkbox"/> Auto/Homeowners Insurance |
| <input type="checkbox"/> Pension Contributions - You must submit a copy of your bi-weekly payroll voucher for each pay period.
Contributions to 547(b) deferred comp accounts are not eligible for flex credit reimbursement. | | |

To file a claim for expenses, please request a copy of a receipt for services from the service provider.

The receipt must include the following information:

- The name of the person for whom the expense was incurred (you, your spouse, your dependents).
- The date of the service provider.
- The name of the service provider.
- A description of the service, or expense.
- The amount or cost of the item, or service provided.

Attach a copy of the receipt(s) for eligible expenses/dues to this form and mail to:

Employee Benefit Specialists, Inc. (or EBS)
P. O. Box 11657
Pleasanton, CA 94588 Fax: 925-460-3929

Be sure to keep a copy of your receipts and claim forms for your personal records. These will not be provided to you from the Recordkeeper.

Reimbursement Request Information

EMPLOYER NAME: _____ PLAN YEAR: _____

EMPLOYEE NAME: _____

<i>Name of person for whom the service was provided</i>	<i>Relationship to Employee</i>	<i>Type of Expense</i>	<i>Date</i>	<i>Amount requested to be reimbursed</i>
Total Requested Reimbursement:				

I certify that the charges for which I am requesting reimbursement have been incurred by me, my spouse, and/or eligible dependents. Furthermore I declare that I am requesting reimbursement only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Direct Reimbursement Plan.

Employee Signature: _____

Date: _____