

Hope College

Flexible Spending Account (FSA) Request for Reimbursement For Benefit Year July 1, 2007 – June 30, 2008

Employee Name (please print): _____

Hope ID #: _____ Date of Request: _____

*In order to be eligible for reimbursement, the expense must 1) be "eligible" (listings available on HR website) and 2) an "eligible receipt" must be attached. An "eligible receipt" for expense is an itemized statement for each expense which includes the provider's name/address, patient name, date and description of service and amount charged (less any insurance payment applied). **Balance forward or paid on account statements cannot be accepted.** An "eligible receipt" for reimbursable over-the-counter medications is a store's receipt which shows the name of the medication/item, date of purchase, and cost. An "eligible receipt" for dependent care expenses must show dates of service(s), name of dependent, and provider name/address. For orthodontic expense, with the first reimbursement request, submit a copy of the Service Agreement/Contract itemizing the treatment period, down payment, monthly payment, and amount covered by insurance (if applicable). For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.*

Medical / Dental / Vision Expenses

Date of Service	Name of Provider <i>(physician, hospital, dentist, pharmacy)</i>	Type of Service <i>(copay, Rx, ortho, OTC meds)</i>	Name of Patient	Amount of Expense to be Reimbursed
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TOTAL REQUESTED MEDICAL REIMBURSEMENT: \$

Child and Dependent Day Care Expenses

Name of Day Care Provider	Dates of Service		Child/Dependent's Name	Is your child/dependent 13 years or younger?	Amount of Expense
	From	To		Yes No	
				Yes No	
				Yes No	
				Yes No	

TOTAL REQUESTED REIMBURSEMENT: \$

Employee Authorization: I request payment from my Flexible Spending Account(s) for the incurred expenses outlined above. I certify that I have not received prior reimbursement under this plan or any other source, I have met all the requirements for eligible health care expenses, and 3) I understand these reimbursed expenses cannot be claimed on my or my spouse's income tax returns.

Employee Signature _____ Date _____

Send claims to Hope College's Human Resources Office, 100 East 8th Street, Suite 210, Holland, MI 49423. Please make copies, if needed, as these documents will not be returned. Reimbursements requests must be received in HR one week prior to payday to be included in your next check. For claim questions, please review the HR website under Benefits/Flex or contact the HR Department at 616.395.7811.

(this section is for HR use only)

ANNUAL GOAL

Total annual compensation set aside under Section 125
 Less: Previous reimbursements
 Plus this reimbursement
 Reimbursements YTD
 Total Remaining

Medical / Dental	Child / Dependent Care
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

Overage Amount Available for Future Reimb: \$ _____