

Return to:
 Madison-Oneida BOCES
 4937 Spring Road, P.O. Box 168
 Verona, NY 13478-0168
 Attn: Flex Plan Office

**FLEXIBLE SPENDING PLAN
 HEALTH CARE ACCOUNT
 REIMBURSEMENT REQUEST FORM**

PERSONAL INFORMATION

Employer Madison-Oneida BOCES		For Plan Year _____	Social Security Number XXX-XX-	
Employee name (Last)	(First)	(Initial)	Telephone Number	Date of Birth
Home Address	Street	City	State	Zip

PERSONAL INFORMATION

NAME OF EMPLOYEE, CHILD OR DEPENDENT RECEIVING SERVICE	RELATIONSHIP TO EMPLOYEE	TYPE OF SERVICE	DATES OF SERVICE		AMOUNT TO BE REIMBURSED
			FROM	TO	

AUTHORIZATION

I certify that the expenses for reimbursement requested from my Health Care Reimbursement Account (HCRA) were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by another plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HCRA. I (or we) understand that expenses reimbursed through the HCRA account can not be used as deductions or credits when filing my (our) income tax return.

 Employee Signature _____ Date

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the bill(s) and an explanation of benefits from your insurance carrier(s).