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

SECTION 105 PLAN
HEALTH CARE ACCOUNT
REIMBURSEMENT REQUEST FORM

PERSONAL INFORMATION

Employer	For Plan Year	Social Security Number
Madison-Oneida BOCES	_____	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	
		RX#			
		RX#			
		RX#			
		RX#			
		RX#			
		RX#			
		RX#			
		RX#			
		RX#			
		RX#			

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 detailed prescription receipt.