

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 <b>Madison-Oneida BOCES</b>		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	
		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.**