

OEM of CT, Inc.
Request for Reimbursement
Unreimbursed Medical/Dependent Care Spending Account

INSTRUCTIONS: Complete requested information (Please print). List each item on a separate line and attach itemized receipts or signed provider certification for each. Send the signed, completed form with receipts to: OEM of CT, Inc. If you have any questions, call: (860) 528-5555.

Employee Name: _____ Social Security Number: _____

Employee Address: _____

Your Company Name: _____ Employee Work Phone: _____

DEPENDENT CARE EXPENSES						
Dependent Name(s)	Age	Service Dates		Provider Name	Provider Tax ID or SSN	Amount Claimed
		From	To			
Total Claim Amount						

(The Provider's tax ID or Social Security Number must be provided to the IRS on your annual Tax return.)

UNREIMBURSED MEDICAL EXPENSES				
Patient Name	Service Date	Service Provider Name	Service Description	Amount Claimed
Total Claim Amount				

I hereby certify that all expenses for which reimbursement is claimed herein were incurred during the period while I was covered under [PEO Company]'s Flexible Spending Account Plan and that such expenses have not been/are not reimbursable under any other source, and cannot be used as a deduction on my personal income tax return. I also understand that I alone am responsible for the accuracy of all information related to this claim, and if the claimed expenses are not proper expenses under the Plan, I may be liable for payment of all related taxes including Federal, state or city income tax on amounts paid under the Plan.

Employee Signature

Date