EAST GEORGIA COLLEGE HEALTH FSA PLAN
REIMBURSEMENT REQUEST FORM

Name:	**Employer ID #:**
Address:	

Please provide the following information (where applicable). Note: Claims must be received by the last Friday of each month in order to obtain reimbursement during the next month; any omissions may unnecessarily delay your benefit reimbursement.

I request $ _____________ in reimbursement for the following Eligible Medical Expenses.

Amount of Expense:	Un-reimbursed Portion:	Incurred By:	Nature of Expense:	Date Incurred:

These expense(s) are Eligible Medical Expense(s) that meet the criteria of tax deductibility pursuant to Section 213 of the Internal Revenue Code, and I have not otherwise been paid through insurance or reimbursed from any other source, and will not be in the future. Eligible Medical Expenses do not include amounts paid for any accident or health insurance premium. Enclosed herewith are written statement(s)/bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s). Also enclosed, if applicable, is an Explanation of Benefits (EOB) form(s) from my primary medical and/or dental insurance carrier(s) indicating the amount(s) which I am obligated to pay.

I agree to notify my Employer if I have reason to believe that any expense(s) for which I have obtained reimbursement is not an Eligible Medical Expense, and also agree on demand to indemnify and reimburse my Employer for any liability it may incur for failure to withhold federal and state income tax or Social Security tax for any reimbursement I receive for an expense which does not qualify as an Eligible Medical expense, up to the amount of additional tax actually owed by me.

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Employee Signature **Date**