PARK COUNTY FLEX PROGRAM
REQUEST FOR REIMBURSEMENT

EMPLOYER: _____

EMPLOYEE NAME (Please type or print):_____ SOCIAL SECURITY #:_____

EMPLOYEE ADDRESS:_____

CITY STATE ZIP

(Please check if this is a new address) ☐

DEPENDENT/CHILD CARE

List each receipt separately (Use additional forms if necessary)

Name of Dependent	Age	Provider Name	Provider ID#	Dates Service Provided	Requested Amount of Reimbursement		

Please attach a receipt or itemized bill listing (A), (B), (C), and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are **not** acceptable.

Provider's Certification/Verification

I certify that the above-described Dependent Care expenses were incurred by the employee named above

_____

Business/Provider Signature Address

Unreimbursed Medical

List each receipt separately (Use additional forms if necessary)

Patient Name	Provider Name	Description of Service	Dates Service Provided	Requested Amount of Reimbursement		

Please attach a third-party receipt, itemized bill or Explanation of Benefits(EOB) listing (A), (B), (C), (D), and (E) or have provider certify below. Cancelled checks, credit card receipts or bills showing a previous balance or balance due only are **not** acceptable.

Provider's Certification/Verification

I certify that the above-described Unreimbursed Medical expenses were incurred by the employee named above

_____

Business/Provider Signature Address

I request reimbursement from my Park County FLEX Program spending account(s) as listed above and certify that these are eligible Medical or Dependent Care Expense that I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expense for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my persona income tax return(s). I understand and agree that Dependent Care Expense must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Date: _____ **Employee Signature:**_____