



DIOCESE OF
FORT WAYNE-SOUTH BEND
 HUMAN RESOURCES

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM

Employee Name _____

Employee SS # _____

Street Address _____

Phone # _____

City _____ State _____ Zip _____

Location Name: _____

Date of Service	Service Provided by	Description of Service	Amount	Office Use

This is to certify that I have incurred expenses that qualify for reimbursement.

I further certify that I have enclosed documentation to substantiate the above amounts. I understand and agree that since these expenses are to be reimbursed, they may not be claimed for income tax purposes.

The medical expenses listed above are not eligible for and have not been reimbursed by an insurance plan.

YOU MUST SIGN AND ENCLOSE RECEIPTS

Dependent Care Provider ID _____

Social Security or Day Care Center Employer ID Required by IRS

Employee Signature _____ Date _____