

**Mott Community College
FlexSave - Request for Reimbursement Form**

(Please Print Clearly)

Name: _____ Last Four Digits of SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Company Name: Mott Community College Work Phone Number: _____

This form may be used for either the health care reimbursement account and / or dependent care reimbursement account requests for reimbursement. This request is for PLAN YEAR: _____

HEALTH CARE REIMBURSEMENT ACCOUNT

Please indicate the amount requested for reimbursement in each category (attach all receipts):

MEDICAL \$ _____ VISION \$ _____ DENTAL \$ _____

DEPENDENT DAYCARE REIMBURSEMENT ACCOUNT

DEPENDENT CARE REIMBURSEMENT AMOUNT (attach all receipts) \$ _____

Name of Dependent(s): _____

Relationship of Dependent: _____

Name of Provider: _____ Provider's Taxpayer ID or SSN (REQUIRED): _____

Daycare Provided: From _____ To _____

Preferred method of reimbursement: Check Direct Deposit

Checking Account Number: _____ Routing Number: _____ Bank Name: _____

I request reimbursement from my account. I certify that the information provided is true and correct, that these expenses are not and will not be covered by any insurance program or other reimbursement program, and that I have not or will not claim these expenses as income tax deductions on my income tax return, and that the expenses submitted qualify as required. I also understand that the Internal Revenue Service may require proof that these are eligible expenses, and that I am responsible for providing such proof.

Total Amount Submitted: \$ _____

Signature (REQUIRED): _____ Date: _____

Send this completed form along with receipts to FlexSave of America • 28104 Orchard Lake Rd. • Suite 140 • Farmington Hills • MI • 48334, or fax to (248) 539-8002

For Questions Call: (888) 231-1363