

FlexSave of America, Inc.

(800) 253-2688

**MOTT COMMUNITY COLLEGE
FLEXIBLE SPENDING ACCOUNT PLAN
REQUEST FOR REIMBURSEMENT FORM**

(Please Print Clearly or Type)

Name _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip _____

Company Name _____ Work Phone Number _____

**THIS FORM MAY BE USED FOR EITHER HEALTH CARE REIMBURSEMENT ACCOUNT OR
DEPENDENT CARE REIMBURSEMENT ACCOUNT REQUESTS FOR REIMBURSEMENT.**

HEALTH CARE REIMBURSEMENT ACCOUNT

Please indicate, within each particular category, the amount requested for reimbursement. Attach copies of bills and any explanation of benefit forms reflecting insurance payments, and mail to: FlexSave of America, Inc. 28104 Orchard Lake Road, Suite #140, Farmington Hills, Michigan 48334. Fax: 248-539-8002

MEDICAL \$ _____

VISION \$ _____

DENTAL \$ _____

DEPENDENT CARE \$ _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT

Attach to this form a receipt for services rendered or statement of expenses and mail to: FlexSave of America, Inc. 28104 Orchard Lake Road, Suite #140, Farmington Hills, Michigan 48334. Fax: 248-539-8002

Name of Dependent(s) _____
Relationship _____

Name of Provider _____ Provider's Taxpayer ID or SS# _____

Dates Care Provided: From _____ To _____

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, 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 _____

Date _____