FPS FILE: **SEA-2003**

SEATTLE PUBLIC SCHOOLS

FLEXIBLE SPENDING ACCOUNT - REIMBURSEMENT REQUEST FORM

FOR PLAN YEAR OF JANUARY 1, 2003 *through* DECEMBER 31, 2003

NOTE: THIS FORM CAN ONLY BE USED FOR SERVICES INCURRED DURING THE PLAN YEAR SHOWN ABOVE.

Please Print or Type

_____-_____-_____
Soc. Sec. Acct. No.

*Last*_____ *First*_____ *MI*_____
Employee name

*Number & street*_____ *City*_____ *State*_____ *Zip*_____
Employee home address

Please check here if this is a change in address ❑ Day phone (_____)_____

please make additional copies of this form for future claims

Health Care Request

These services *MUST* have been incurred during the current plan year as shown on the top of this form.
You *MUST* attach a copy of the provider's bill or insurance company's "Explanation of Benefits" verifying the date of service, type of service, name of person receiving service and the cost, to the back of this form.
Use additional sheets if necessary.

DATE AND TYPE OF SERVICE(S) INCURRED & COST

Date	Type	For whom	Cost
			$
			$
			$
			$

Total amount of attached bills, EOB's, etc. **$**_____

Less Amount(s) from other sources. **$**_____

See IRC Section 213 for qualifying Health Care expenses or consult your tax advisor for more information.

TOTAL HEALTH CARE AMOUNT REQUESTED **$** 1

Dependent Day Care Request

These services *MUST* have been incurred during the current plan year as shown on the top of this form.
You *MUST* attach a copy of the provider's bill or a receipt verifying the name of the care provider, the provider's Tax I.D. or Social Security Number and signature, the date(s) of service and the cost, for *ALL* requests, to the back of this form.
Use additional sheets if necessary.

Note: Kindergarten is not an allowable expense
Before and after Kindergarten care is allowable

DEPENDENT CARE PROVIDER INFORMATION & COST

1. Provider's Name_____ Tax I.D or Soc. Sec.#_____
Date(s)_____ **Cost $** _____
Name of child_____ Age of Child_____

2. Provider's Name_____ Tax I.D or Soc. Sec.#_____
Date(s)_____ **Cost $** _____
Name of child_____ Age of Child_____

See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information.

TOTAL DEPENDENT CARE AMOUNT REQUESTED **$** 2

Premium Reimbursement Account

This is for reimbursement of insurance premiums paid by you for your personal medical, dental, vision and/or disability insurance. *DO NOT REQUEST REIMBURSEMENT FOR PREMIUMS YOUR EMPLOYER PAYS*. A copy of your insurance company's "premium due notice" or bill *MUST* be attached to the back of this form and cannot be returned.
Use additional sheets if necessary.

INSURANCE POLICY INFORMATION & COST

1. Insurance Co._____ Period of coverage_____
Type of insurance_____ **Premium Cost $** _____

2. Insurance Co._____ Period of coverage_____
Type of insurance_____ **Premium Cost $** _____

TOTAL PREMIUM REIMBURSEMENT AMOUNT REQUESTED **$** 3

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I am claiming reimbursement only for eligible expenses incurred by myself, spouse and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance.
I hereby authorize my Flexible Spending Account to be reduced by the amount(s) shown above.

Participant's signature **X** **Date**

Send completed form and all documentation to:

FLEX PLAN SERVICES, INC.
PO Box 70366
Bellevue, WA. 98005
FAX: (425) 451-7002 or toll free (866) 535-9227

If you have questions or need assistance call (425) 452-3500 or 1(800) 669-FLEX
Visit our web site at www.flex-plan.com