FLEX PLAN REIMBURSEMENT REQUEST
*****Maintain Copy for your Records

Mail to:
MEDCOM
Flex Division
1061 Riverside Ave ◆ Jacksonville, FL. 32204
Office: 800-523-7542
Fax: 866- 598-7800

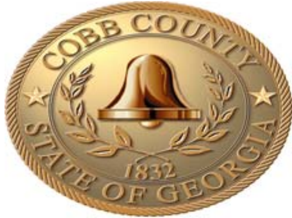
EMPLOYEE NAME________________________________
SOCIAL SECURITY #______________________________
LOCATION ___________________________________

❑ If Address Changed, Please "Check" and Complete Following:

____
New Street Address
____
City State Zip

❑ If Name Changed, Give former name:

COBB COUNTY BOARD OF COMMISSIONERS



FLEXIBLE BENEFIT PLAN

I AM REQUESTING REIMBURSEMENT FOR: ❑MEDICAL CARE (MC) ❑DEPENDENT CARE (DC)
TOTAL REQUESTED: $______________ $______________

Itemize expense and attach documentation (Insurance Explanation Of Benefits; Medical Provider Invoice with Diagnosis; Payment Receipts; Day Care Bill, etc):

Expense Incurred By	Self	Spouse	Child	Date Birth	Name of Provider of Service (**if Dependent Care, include Tax ID No.)**	Date Incurred	MED CARE	DEP CARE

(Self / Spouse / Child: Check One; Med Care / Dep Care: Check One)

Supporting documentation is attached to this request for reimbursement. I hereby certify that the requested reimbursements are for eligible services received by either myself or my eligible dependents, if any, as claimed under my income taxes. If the expenses are for dependent day care, I understand and agree that I can not claim the federal income tax credit for dependent day care expenses submitted hereunder. I further understand that the taxpayer identification numbers of day care providers will be included on any federal tax return filed by me. I also certify that none of the expenses I am submitting are payable by any other source.

Employee Signature____ **Date** ______________________

Instructions for filing your request for reimbursement: ALL EXPENSES SUBMITTED FOR REIMBURSEMENT MUST BE INCURRED AND PAID FOR BY YOU IN THE FLEXIBLE BENEFIT PLAN YEAR.

1. **FOR MEDICAL/DENTAL/VISION EXPENSES:**
   ■**Expenses Covered Under Your Health Care Plan** Attach the EOB or other proof of expense (medical provider's statement which includes patient's name, date of service, treatment/diagnosis) which is your portion of the expenses not paid by your health care plan. Refer to your copy of the Summary Plan Description of the Plan Document for detailed Plan information.
   ■**Expenses Not Covered Under Your Health Care Plan** - (such as pre-existing conditions, uncovered dependents or non-covered prescription drugs) can be immediately sent in for reimbursement. Please write across receipt - **"NOT COVERED BY HEALTH PLAN"**
2. ■Eligible expenses can be for you or any member of your family that is claimed on your income taxes. Your dependents do not have to be enrolled in your health plan to be eligible.
3. Refer to your copy of the Summary Plan Description or the Plan Document for detailed Plan information.
4. **FOR DEPENDENT DAY CARE EXPENSES:**
   ■Attach a receipt or bill that includes the Dependent's Name; Name of Day Care Provider; Day Care Provider's Tax I.D. Number; Date of Service (from and through); and the Amount of the Day Care Expense.