

COLLEGE of VISUAL ARTS

Flexibal Benefit Accounts Expense Verification Form for Reimbursements

Employee _____ Date _____ Plan Year _____

Signature _____ Date _____

MEDICAL/DENTAL UNREIMBURSED EXPENSES

This includes deductibles, coinsurance, dental payments, vision and hearing, and prescriptions.
Attach copy of receipts.

Date of Expenses	Type of Expenses	Reimbursement Amount
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
Total Unreimbursed Medical/Dental Reimbursement		_____

CHILD CARE REIMBURSEMENT ACCOUNT EXPENSES

Date of Expenses	Type of Expenses	Reimbursement Amount
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
Total Child Care Reimbursement Request		_____

I request that the expenses listed above be paid to me from my cafeteria compensation expense reimbursement account(s). I certify that I have not and will not be reimbursed for these amounts from any other source. These expenses were incurred while I have been a covered participant and to the best of my knowledge are reimbursable by the plan. I further certify that I have receipts supporting all expenses and agree to make such receipts available to the company on request if not submitted with this request.

Business Office Use Only

Date Received:	Medical/Dental
Received by:	Child Care
Approved by:	Total <input style="width: 150px;" type="text"/>
PO # : Medical / / 20 # _____	<i>Example: Medical 1/1/2011 #1 Keegan</i>
GL Code: 100-2230	