

REQUEST FOR REIMBURSEMENT

INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM MAY DELAY THE PROCESSING OF YOUR CLAIM. Complete **PART I** of the form. Complete **PART II** of the form indicating the type of expense (Medical or Daycare), the incurred date(s) of the expense, a brief description (for example, Orthodontia, Prescription, Office visit, Dental, etc.), and the amount of the incurred expense. Attach **COPIES** (do not send originals) of the receipts for each expense showing the **incurred date** (not the paid date) and the amount. **If you are submitting more than one expense, number the copies to correspond to the number of the line on which the expense is listed.** Total the amount of your claim. You have 60 days after plan year to submit claims for that year. Please read and complete **PART III** of the form and send to the County Clerk's Office, Payroll Department, at 307 Main Street, Black River Falls, WI 54615

EMPLOYEE INFORMATION

PART I _____

PLEASE PRINT

Social Security Number (last 4) # _____

Name _____ Work Phone _____

Address _____

City _____ State _____ Zip Code _____

Employer _____

REIMBURSEMENT INFORMATION

PART II _____

TYPE CODES: M = Unreimbursed medical/dental/optical D = Daycare

TYPE CODE	SERVICE DATE(S) FROM - TO	PROVIDER NAME	DEPENDENT NAME	AMOUNT	OFFICE USE
1. _____	_____ - _____	_____	_____	_____	_____
2. _____	_____ - _____	_____	_____	_____	_____
3. _____	_____ - _____	_____	_____	_____	_____
4. _____	_____ - _____	_____	_____	_____	_____
5. _____	_____ - _____	_____	_____	_____	_____

(For additional claims, use another reimbursement application) **TOTAL** _____

EMPLOYEE AUTHORIZATION

PART III _____

I certify that the above information is correct and that the expenses claimed were incurred by me or by my eligible dependents after my effective date of coverage in the Jackson County Flexible Spending Plan but prior to the end of the plan year. I further declare that these expenses have not been and will not be paid under insurance or any other benefit program and that I have not and will not claim these expenses on my personal income tax return.

EMPLOYEE

SIGNATURE _____ **DATE** _____