

# Flexible Spending Account Request for Reimbursement CLAIM FORM



<b>Employer Name:</b>	City of Idaho Falls			
<b>Employee Name:</b>	Last	First	SS#	
<b>Employee Address:</b>	Street	City	State	ZIP
<b>Email Address:</b>	PHONE ( )			

Please check if this is a new address

*Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.*  
 ➤ **ALL REQUESTS FOR REIMBURSEMENT MUST BE SUBMITTED NO LATER THAN DECEMBER 30th.**

\* Information below must be completed

MEDICAL EXPENSE CLAIMS						
mySourceCard® Transaction	Dates of Service	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<input type="checkbox"/> Yes <input type="checkbox"/> No						\$
<b>Total:</b>						\$

DEPENDENT CARE CLAIMS							
Date of Service From	Date of Service To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
<b>Total:</b>							

### EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR FASTEST REIMBURSEMENT, FAX TO: 208-529-4698**  
**EMAIL TO: CS@AMERINS-SERV.COM**  
**OR MAIL TO: PO BOX 1766, IDAHO FALLS, ID 83401**