

VALENCIA COMMUNITY COLLEGE FLEXIBLE BENEFITS

Flexible Benefits Reimbursement Claim Form

Employee Name _____

Employee VID _____

Mail Code _____

Campus Extension _____

INSTRUCTIONS:

List health and dependent care expenses separately. Attach copies of bills/explanations of benefit forms as appropriate. Receipts for over-the-counter products must include the date of purchase, purchase price, and name of the product. For dependent care expenses you must provide the name, address, social security number or federal income tax ID number of the service provider. However, this information is not required for a tax exempt organization.

EMPLOYEE / DEPENDENT HEALTH CARE EXPENSES

TYPE OF EXPENSE	SERVICE DATES From To	NAME OF PATIENT\RELATIONSHIP	PROVIDER OF SERVICE	AMOUNT REQUESTED

TOTAL AMOUNT REQUESTED _____

DEPENDENT CHILD CARE EXPENSES

NAME OF DEPENDENT AND RELATIONSHIP	PERIOD OF DEPENDENT CARE	DEPENDENT CARE PROVIDER	AMOUNT REQUESTED

TOTAL AMOUNT REQUESTED _____

I certify that I have actually incurred these expenses and I have not previously been reimbursed for them. I understand that any amounts reimbursed cannot be claimed on my and/or my spouse's personal income tax for the purpose of income or tax reduction.

Signature _____

Date _____

HUMAN RESOURCES	PAYROLL
Amount to be reimbursed	Date reimbursed
Signature	Signature
Date	Date