

2009

VALENCIA COMMUNITY COLLEGE FLEXIBLE BENEFITS

Flexible Benefits Reimbursement Claim Form

Employee Name \_\_\_\_\_

Employee V-Number \_\_\_\_\_

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

Table with 5 columns: TYPE OF EXPENSE, SERVICE DATES (From To), NAME OF PATIENT\RELATIONSHIP, PROVIDER OF SERVICE, AMOUNT REQUESTED

TOTAL AMOUNT REQUESTED \_\_\_\_\_

DEPENDENT CHILD CARE EXPENSES

Table with 4 columns: 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 \_\_\_\_\_

Table with 2 columns: HUMAN RESOURCES, PAYROLL. Rows include Amount to be reimbursed, Signature, and Date.