SCHOOL DISTRICT OF WESTFIELD

SECTION 125 – FLEXIBLE BENEFIT PLAN
REQUEST FOR REIMBURSEMENT

Employee Name (please print) _____ Date _____

Dependent Care Assistance Plan (DCAP)

List each receipt separately. Use additional forms if necessary. Staple receipts to back in order listed.

Dependent Name	Age	Provider Name	Date Service Provided	Requested Amount
			TOTAL	$

Use the Provider Certification below **only if no receipt is attached**.

Provider Certification: I certify that the Participant named above incurred the Dependent Care expenses listed above.

Provider Address: Street_____ City _____ State _____ Zip _____

Provider Signature _____ SS#_____ Date _____

Health Flexible Spending Account (Health FSA)

List each receipt separately. Use additional forms if necessary. Staple receipts to back in order listed.

Patient Name	Provider Name	Description of Services	Date Service Provided	Requested Amount
			TOTAL	$

Use the Provider Certification below **only if no receipt is attached**.

Provider Certification: I certify that the Participant named above incurred the Health Care expenses listed above.

Provider Address: Street_____ City _____ State _____ Zip _____

Provider Signature _____ Date _____

Information and Signatures

By submitting this claim form, I request reimbursement from my Flexible Benefit Plan as listed above. I agree to the Terms and Conditions of the Flexible Benefit Plan Document. I certify that these are eligible medical and/or dependent care expenses that my dependents or I have incurred and that they have not and will not be reimbursed from another source. (e.g. health insurance, another employer's FSA)

Employee Signature _____