

**MONMOUTH COLLEGE #039
FLEXIBLE SPENDING REIMBURSEMENT FORM**

Claims must be received at SISCO, two (2) business days before your scheduled flexible spending run.

Participant Name _____ Participant ID # _____

MEDICAL/DENTAL EXPENSES -- ATTACH EOBS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				

DAYCARE CARE EXPENSES -- ATTACH BILLS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				

*Dependent Care Expenses - If the amount of the above expenses exceeds the balance in your account, do not resubmit for the unreimbursed portion on this claim. You will automatically be reimbursed as your account balance allows.

I hereby certify that:

- **The information given on this reimbursement form is complete and accurate.**
- **I have not previously received reimbursement for these expenses from this Flex account or from any other source.**
- **The total of reimbursed dependent care expenses does not exceed the lesser of my spouses or my earned income (W-2 Pay) for the year, if less than \$5,000.**
- **All health and dependent care expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Packet**

(Signature)

_____/_____/_____
(Date)

KEEP A COPY FOR YOUR FILES

**MAIL TO:
ATTENTION: Flexible Spending Dept., SISCO, P.O. Box 389, Dubuque, IA 52004-0389
Fax: 563-587-5703**