



**UTAH SCHOOL BOARDS ASSOCIATION**

860 East 9085 South \* Sandy, Utah 84094  
801-566-1207 \* Fax 801-561-4579



*Sogowee Utah Schoolbo...  
... State Association...*

**HEALTH CARE REIMBURSEMENT REQUEST**

**EMPLOYEE INFORMATION**

(Please Print - Last, First, MI)

Daytime Phone Number

Employee Soc. Sec. No.

Employee Home Address

City

State

Zip Code

**HEALTH CARE EXPENSES**

Patient's Full Name	Relationship	Birth Date	Date of Service From – To	Type of Service (Medical, Dental, or Vision)	Reimbursement Request Amount
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

**TOTAL \$** \_\_\_\_\_

**EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT**

I hereby authorize release of payment through my Flexible Spending Account(s). I hereby authorize your company or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account(s).

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE ATTACH APPROPRIATE RECEIPTS TO SUPPORT YOUR CLAIM**