

Reimbursement requested for: Current Year Prior Year



REGIONAL CARE, INC. SELECT FLEX

Spending Accounts Claim Form

Remit to: Regional Care, Inc.
905 West 27th Street
Scottsbluff, NE 69361

Phone (308) 635-2260
Fax (308) 635-1241
Watts 1-800-795-7772

EMPLOYEE INFORMATION	
Please type or print.	
Name: _____	Employer: _____
Telephone Number/Ext: _____	Date Submitted: _____

MEDICAL EXPENSES						
Dependent Name	Age	Relationship to Employee	Provider	Date of Service	Type of Unreimbursed Medical Expenses	Amount
Total Medical Reimbursement Requested \$						_____
<small>I request payment from my spending account for these itemized expenses. I certify that I have not requested reimbursement under this plan or from any other source of these expenses. I certify that I have met all of the requirements for eligible health care expenses as described on the back side of this form. I understand that expenses paid through these accounts cannot be claimed on my personal income tax form.</small>						
Signature _____			Date: _____			

DEPENDENT CARE EXPENSES				
Name	Age	Relationship to Employee	Date of Service	Amount
Total Dependent Care Reimbursement Requested \$				_____
Name and address of individual or institution providing day care services:				
Name _____ Address _____				
Social Security number of person providing day care: _____ - _____ - _____				
<small>I request payment from my spending account for these itemized expenses. I certify that I have not requested reimbursement under this plan or from any other source of these expenses. I certify that I have met all of the requirements for eligible day care expenses as described on the back side of this form. I understand that expenses paid through these accounts cannot be claimed on my personal income tax form.</small>				
Signature _____			Date: _____	

INDIVIDUAL PREMIUM REIMBURSEMENT ACCOUNT			
Date of Expense	Name of Insurance	Description	Amount
Total Reimbursement Requested \$			_____
<small>I request payment from my spending account for these itemized expenses. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I certify that I have met all of the requirements for qualified transportation arrangement expenses as described on the back side of this form. I understand that expenses paid through these accounts cannot be claimed on my personal income tax form.</small>			
Signature _____			Date: _____