FLEX ONE

AFLAC

FLEX ONE USE ONLY

Request for Reimbursement

Employer: _____

Employee name (Please type or print.): _____ Social Security #: _____

Employee address: _____

City State Zip

(Please check if this is a new address. ☐)

Dependent/Child Care Flex

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

A Name of Dependent	Age	B Provider Name	Provider ID #	C Dates Service Provided	D Requested Amount of Reimbursement	FLEX ONE Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

Provider's Certification/Verification

I certify that the above-described Dependent Care expenses were incurred by the employee named above.

Business/Provider **Address** **Date**

Unreimbursed Medical

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

A Patient Name	B Provider Name	HMO	C Description of Service	D Dates Service Provided	E Requested Amount of Reimbursement	FLEX ONE Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Cancelled checks, credit card receipts or bills showing a previous balance or balance due only are not acceptable.

Provider's Certification/Verification

I certify that the above-described Medical Care expenses were incurred by the employee named above.

Business/Provider **Address** **Date**

I request reimbursement from my FLEX ONE® Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Care Expenses that I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expenses for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Care Expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Date: _____ **Employee Signature:** _____

(See reverse for instructions.)