Riverhead Central School District
201__
Flexible Spending Account Claim Form

Your Name	S.S. Number - Last 4 Digits		Building/Location
Your Street Address	**City**	**State**	**Zip**

Unreimbursed Medical Expenses

Receipts must include description of service, date of service and amount

Nature of Service	Date (s)	Amount
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
	TOTAL	$

Dependent/Child Care Expenses

Submit receipt including date of service, amount and Tax ID #

Name of Day Care Provider	Tax ID #

Name of Dependent	Age

Description of Service	Date	Amount
		$
		$
		$
		$
		$
	TOTAL	$

READ CAREFULLY AND SIGN:

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage, I shall return the monies paid to me by this plan for recrediting of my account. I hereby request that the plan reimburse me for the expenses identified in this voucher and attachments.

______________________________ EMPLOYEE SIGNATURE

______________________________ DATE

For District Office Use

Medical Expenses

Available Employee Contribution	Claim Approved	Available Remaining Balance
______________	______________	______________

____
Approval Signature Date

Dependent Care Expenses

Approved Claim Amount	Balance Available	Remaining Claim Balance
______________	______________	______________

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Approval Signature Date