SECTION 125 FLEXIBLE BENEFIT PLAN

EXPENSE REIMBURSEMENT VOUCHER

Name of Employer ORCUTT UNION SCHOOL DISTRICT		Daytime Phone (area code)
Name of Employee (Last, First, M.,)		Social Security No.
Address	City & State	Zip Code
Email Address		

☐ CHECK HERE IF THIS IS A NEW ADDRESS ☐ CHECK HERE IF YOU HAVE OTHER AF INSURANCE

Please complete the worksheet below by indicating the date your expense was incurred, the type of expense being reimbursed, the name of person for whom expense was incurred, and the amount of the expense. Only include expenses for you or your dependents and expenses for which you have not previously filed for reimbursement.

Date of expense	Type Of Expense		Name Of Person For Whom Expense Was Incurred	Amount Of Expense	
	Medical	Dep. Care		Medical	Dep. Day Care
	☐	☐	TEST	$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
	☐	☐		$0.00	$0.00
			TOTAL	$0.00	$0.00

MEDICAL EXPENSES: For each medical expense listed above, attach the statement you received when the service was provided or the insurance company statement of benefits. For expenses that are or may be covered under a health insurance plan, submit your bills to the insurance company(ies) and then submit the insurance company statement of benefits showing the amount of expenses not covered by insurance with this form. For prescription drugs, attach the original pharmacy statement – a cash register tape is not acceptable. You should keep a copy of each statement, bill, or insurance company statement of benefits submitted with form for your records.

DEPENDENT DAY CARE EXPENSES: For each dependent day care expense listed above, attach a completed Dependent Day Care Provider Acknowledgment form which has been signed by your dependent day care provider.

I HEREBY CERTIFY that the expense(s) shown above has not been, and will not be paid or reimbursed by an insurance company or from any other source and is medically necessary. I understand that any amounts not used for qualified expenses by the end of the plan year will be forfeited to my employer.

_____ _____

Employee Signature Date

NOTE: MEDICAL EXPENSE WHICH HAVE BEEN REIMBURSED UNDER THIS PLAN ARE NOT DEDUCTIBLE BY THE EMPLOYEE FOR FEDERAL INCOME TAX PURPOSES

TELEPHONE NUMBER	FAX NUMBER:	AMERICAN FIDELITY ASSURANCE COMPANY
1 (800) 325-0654	1 (800) 543-3539	Flex Account Administration Po Box 25510 Oklahoma City, Ok 73125