



Benefit Reimbursement Voucher

Plan Year From: _____ through _____

Employee: _____ SS # _____

In accordance with Internal Revenue Code 125, changes to your plan cannot be made during the plan year unless there is a change in family status (i.e. marriage, divorce, birth of a child, adoption or employment status change of you or your spouse). You must notify us of any changes in order to modify this declaration.

By submission of this reimbursement request I certify that the expenses listed below are eligible expenses. I also understand that should the Actual Expenses incurred be less than the Declared Expenses, such balance shall stay with the employer. I also acknowledge that I have attached copies of supporting documents such as receipt copies, EOBs, etc. allowed under regulation 1.105 to corroborate the Actual Expenses incurred. I understand that my annual unreimbursed medical account is available to me with proper verification. I also understand that I need to keep the original receipts in case of an IRS audit. .

	ACTUAL EXPENSES
Unreimbursed medical, dental expenses, etc.	\$ _____
Child/Dependent day care expenses	\$ _____
Total Expenses	\$ _____

Employee Signature

Date

FOR REIMBURSEMENT, this voucher must be completed and returned directly to Provest Flexible Benefits (formerly New Liberty Administrators).