



Plan Year January 1, 2008 – December 31, 2008

Medical Spending Account Reimbursement Claim Form

Employee Name: _____

SS#: _____ - _____ - _____

Address: _____

City/State/Zip: _____

INSTRUCTIONS

1. For medical / dental expense claims that were submitted to a medical plan or an insurance company, but not paid by the insurance carrier, may be submitted. Please send an explanation of benefits with this reimbursement form to establish amounts not covered under the medical/dental plan.
2. For all other reimbursable expenses, copies of all bills must be attached which show name and address of who rendered the service, reason for charge and date with amount of charge.

** (Example medical/dental co-pays, deductible, prescribed prescriptions and optical expense amount that is not covered or reimbursable from the insurance carrier maybe submitted.)

3. Submit this form with receipts to **HR** by fax, mail or inner office mail. Retain a copy for your records. If you have any questions please contact the Tammy in **HR** department at (518) 389-2104.

EXPENSES

	Name of person expense item for:	Reason for expense:	Total Amount Paid:
1.	_____	_____	\$ _____
2.	_____	_____	\$ _____
3.	_____	_____	\$ _____
4.	_____	_____	\$ _____
5.	_____	_____	\$ _____
6.	_____	_____	\$ _____
			Total \$ _____

Employee Certification

I hereby certify that all items requested to be reimbursed comply with Hoffman Car Wash Inc. flexible spending account and such items have not and will not be covered by any other plan or program of any employer or person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature

Date