MOC-FLOYD VALLEY COMMUNITY SCHOOLS
Medical Expense Reimbursement Flex 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 that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) 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 who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts.

3. Submit this form to: _Three Rivers Benefit Corporation___. Retain a copy for your records.

Expenses

Expenses (list below)

Item	Date Expense Paid	Reason for Payment**	Amount Paid
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

** Use the following letter designation for "Reasons for Payment":

A. medical/dental expense submitted to insurance company but not paid by the carrier (for example; a co-insurance or deductible amount);
B. medical/dental expense not covered by a benefit plan;
C. optical expenses.

Employee Certification

I certify that all items requested to be reimbursed comply with MOC-FLOYD VALLEY COMMUNITY SCHOOLS Flexible Spending Account Program and such items have not and will not be covered by any other plan or program of any employer or other person. MOC-FLOYD VALLEY COMMUNITY SCHOOLS does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature _____Date: _____

Three Rivers Benefit Corporation
PO BOX 3440 Sioux City, IA 51102
(712) 258-1525 PH
(712) 255-3521 FAX