Return to:
Madison-Oneida BOCES
4937 Spring Rd, P.O. Box 168
Verona, NY 13478-0168
Attn: Flex Plan Office

FLEXIBLE SPENDING PLAN
HEALTH CARE ACCOUNT
REIMBURSEMENT REQUEST FORM

PERSONAL INFORMATION

Employer **Camden Central School**	For Plan Year 20 _____	Social Security Number XXX-XX-

Employee name (Last) (First) (Initial)	Telephone Number	Date of Birth

Home Address Street City State Zip

PERSONAL INFORMATION

NAME OF EMPLOYEE, CHILD OR DEPENDENT RECEIVING SERVICE	RELATIONSHIP TO EMPLOYEE	TYPE OF SERVICE	DATES OF SERVICE FROM	DATES OF SERVICE TO	AMOUNT TO BE REIMBURSED

AUTHORIZATION

I certify that the expenses for reimbursement requested from my Health Care Reimbursement Account (HCRA) were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by another plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HCRA. I (or we) understand that expenses reimbursed through the HCRA account can not be used as deductions or credits when filing my (our) income tax return.

Employee Signature _____ Date _____

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the bill(s) or an explanation of benefits from your other insurance.