



245 Landa St. New Braunfels, TX 78130
Tel. 830-606-5100 Fax 830-606-2558
www.riatafinancial.com

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT CLAIM FORM

Check here if address has changed

EMPLOYEE INFORMATION (Please print)

Name: _____ Social Security # _____

Address: _____ School District: _____

City, State, Zip: _____ Phone: (____) _____

Email Address: _____ Fax: (____) _____

UNREIMBURSED MEDICAL EXPENSES

Receipt must include the provider's name, address, date of service, service provided and amount.

Total of unreimbursed medical expense receipts attached: _____

READ CAREFULLY: The above is true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s). I have submitted any medical expenses covered by other medical plan(s) to those plans, but payments have been denied in full or in part, as shown on the attached form. Receipts from my service provider(s) for all expenses are attached to this voucher. I understand that I can not claim any reimbursement expenses on my income tax return, and the I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Signature

Date