Canajoharie Library & Arkell Museum

**Flexible Spending Account –** Medical Expense Claim Form

Employee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All claims require copies of bills/statements/receipts showing date and service. (IRS regulation). Cancelled checks/bank statement/credit card receipts are not adequate substantiation. Expenses must be incurred during the plan year or before the termination date of employment to be reimbursed.

DATE VENDOR CLASSIFICATION (Medications, etc) AMOUNT

Total Reimbursement Request $\_\_\_\_\_\_\_\_\_

CERTIFICATION

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer’s cafeteria plan. I have not been and will not be reimbursed for these expenses from any source including, but not limited to, insurance, this plan, or other programs offered by my, or my spouses, employer. I understand these expenses may no longer be claimed as deductions for income tax purposes since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge I am solely liable for any taxes or penalties on ineligible expenses submitted through the medical flexible spending account. I, and only I, am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses, and, if applicable, reaffirm the authorization provided to the Canajoharie Library & Art Gallery to directly deposit the reimbursement into my bank.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_