Riata Financial Group

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FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT CLAIM FORM

☐ Check here if address has changed

EMPLOYEE INFORMATION (Please Print)

Name: _____ Social Security #: _____

Address: _____ Employer: _____

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

Email Address: _____ Fax: (_____) _____

UNREIMBURSED MEDICAL EXPENSES (Attach Supporting Documentation)

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

Person for Whom Expense was Incurred	Date Of Service	Name of Service Provider	Description of Services	Amount
			TOTAL UNREIMBURSED MEDICAL EXPENSES	

DEPENDENT CARE EXPENSES (Attach Supporting Documentation)

Receipt must include the provider's name, address, Fed. I.D.#, dates of service and amount

Name of Dependents and Ages	Service Date From To	Name, Address and Social Security Number or Tax Identification Number of Service Provider	Amount
		TOTAL UNREIMBURSED MEDICAL EXPENSES	

I certify that I have provided dependent care as described on the back of this form and noted above. I have received _____ as payment for the services I rendered on the dates listed above.

_____ Provider Social Security # or Taxpayer ID #

_____ Signature of Dependent Care Provider

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 has 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 cannot claim any reimbursement expenses on my income tax return, and that 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