Glynn Griffing & Associates
Administration
P. O. Box 16509
Jackson, MS 39236-6509

Company Name: _____

REIMBURSEMENT REQUEST FOR YOUR FLEXIBLE BENEFITS PLAN

Please complete this form in its entirety. Attach a written statement from an independent third party for each amount claimed stating that the expense has been incurred, the nature of the expense, the amount of the expense, and the date of service. Cancelled checks, Balance Forward, paid on Account Receipts will not be acceptable.

Employee Name: _____ Employee Social Security Number: _____

Medical Care Expenses

Date of Service	Name of Person for Whom Expense Was Incurred	Relationship To Employee	Name of Entity Providing Service	Description of Services	Reimbursement Amount

Dependent Care Expenses

Date of Service	Name of Person for Whom Expense Was Incurred	Relationship To Employee	Name of Entity Providing Service	Description of Services	Reimbursement Amount

To the best of my knowledge and belief, the expense(s) listed on this voucher are asccurate and complete and are eligilible for reimbursemnet under the Plan. I certify that these expenses will not be claimed again when filing I.R.S. Form 1040. I certify that these expenses were incurred for eligilbe fiamily members.

I certify that any medical or dependent care expenses have not been reimbursed and are not reimbursable under any other coverage. With regard to dependent care expenses, I certify that I will include the name, address, and tax payer identification number of the service provider on my income tax return. I certify that dependent care expenses have not been paid to anyone claimed as a dependent on my income tax return.

I certify tht if my employer incurs a liabilty for failure to withhold Federal, State or Local Income taxes or Social Security Taxes on one or more payments or reimbursements that are not Qualifying Expenses, I will indentify and reimburse the employer that liability on demand.

Employee's Signature: _____

Date of Request: _____