Reimbursement requested for: Current Year ☐ Prior Year ☐

REGIONAL CARE, INC.

Spending Accounts Claim Form

SELECT FLEX

Remit to: Regional Care, Inc.
905 West 27th Street
Scottsbluff, NE 69361

Phone (308) 635-2260
Fax (308) 635-1241
Watts 1-800-795-7772
Email: rci-flex@regionalcare.com

EMPLOYEE INFORMATION

Please type or print.

Name: _____ Employer: _____

Telephone Number/Ext: _____ Date Submitted: _____

MEDICAL EXPENSES

Dependent Name	Age	Relationship to Employee	Provider	Date of Service	Type of Unreimbursed Medical Expenses	Amount

Total Medical Reimbursement Requested $_____

I request payment from my spending account for these itemized expenses. I certify that I have not requested reimbursement under this plan or from any other source of these expenses. I certify that I have met all of the requirements for eligible health care expenses. I understand that expenses paid through these accounts cannot be claimed on my personal income tax form.

Signature _____ **Date** _____

DEPENDENT CARE EXPENSES

Name	Age	Relationship to Employee	Date of Service	Amount

Total Dependent Care Reimbursement Requested $_____

Name and address of individual or institution providing day care services:

Name _____ Address _____

Tax ID Number or Social Security Number of institution/person providing day care: _____

I request payment from my spending account for these itemized expenses. I certify that I have not requested reimbursement under this plan or from any other source of these expenses. I certify that I have met all of the requirements for eligible day care expenses. I understand that expenses paid through these accounts cannot be claimed on my personal income tax form.

Signature _____ **Date** _____