



ICUBA-MEDICAL AND DEPENDENT CARE EXPENSE ACCOUNT REIMBURSEMENT REQUEST FORM

Part of this claim is to be applied preexisting receipt request.

- Barry University
- Beacon College
- Clearwater Christian College
- Edward Waters College
- Florida Institute of Technology
- Florida Memorial University
- ICUBA Management

- Nova Southeastern University
- Palm Beach Atlantic University
- Rollins College Saint Leo University
- Saint Edwards School
- Saint Leo University
- The University of Tampa

Requested Receipt Total \$ _____

Name	SS#	Mail of fax claims to: ICUBA P.O. Box 616927 Orlando, FL 32821 Toll-free phone: 866.377.5102 Toll-free fax: 866.377.5180 Email: benefitsadministration@icuba.org
Home Address	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No	
City	State _____ Zip _____	
Phone: Work _____ Home _____	E-Mail _____	

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete, it will be returned to you.

TYPE OF CLAIM: <input type="checkbox"/> FSA <input type="checkbox"/> HRA Medical Expenses (If necessary, attach additional sheets)					
	Provider of Service (Doctor, dentist, pharmacy, etc)	Person Receiving Service	Date of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1					
2					
3					
4					

TYPE OF CLAIM <input type="checkbox"/> DCSA Dependent Care Expenses						
	Provider of Service	Person Receiving Service	Age of Dependent	Dates of Service M/D/YR -- M/D/YR	Amount of Expense Claimed	Provider Tax I.D. Number (Social Security Number if Individual)
1						
2						
Dependents Care Provider's Signature (If individual) _____						

I request payment for my health care expense or dependent day care expense account as indicated above for the expense listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement for eligible expenses incurred during the plan year and for my eligible dependents. I certify that these expenses have not and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to reimburse me by the amount requested.

Employee Signature _____ Date _____

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS