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 ☐ Yes ☐ 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: ☐FSA ☐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 ☐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 my by the amount requested.

Employee Signature_____Date_____

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS