## SHELBYVILLE CENTRAL SCHOOL CORPORATION FLEXIBLE BENEFITS PLAN

## REQUEST FOR REIMBURSEMENT

Name (please print) ______________________________

Address ______________________________

______________________________

Social Security Number ______________________________

Location ______________ Job Classification ______________

Request Type: (   ) Health Care Expenses (IRC 106)

(   ) Dependent Care Expenses (IRC 129)

| DATE | PROVIDER | EIN OR SSN | AMOUNT |
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(Please Attach Proof of Payment)

The Provider's Employer Identification Number or Social Security Number must be provided in order to reimburse a Dependent Care Expense Claim.

I affirm that the above request for reimbursement are expenses recognized by the Internal Revenue Code as tax deductible expenses under Section 125 and assume all responsibility for taxes or penalties arising out of any disallowed deductions.

______________________________ Signature

______________ Date