Return to:
Madison-Oneida BOCES
4937 Spring Road, P.O. Box 168
Verona, NY 13478-0168
***Attn: Flex Plan Office***
315-361-5513

# SECTION 105 PLAN
# HEALTH CARE ACCOUNT
## REIMBURSEMENT REQUEST FORM

## PERSONAL INFORMATION

| Employer | For Plan Year | Social Security Number |
|---|---|---|
| **Oneida City School** | _____ | XXX-XX- |

| Employee name (Last) (First) (Initial) | Telephone Number | Date of Birth |
|---|---|---|
| | | |

Home Address Street City State Zip

## PERSONAL INFORMATION

| NAME OF EMPLOYEE, CHILD OR DEPENDENT RECEIVING SERVICE | RELATIONSHIP TO EMPLOYEE | PRESCRIPTION # | DATE OF SERVICE | DEDUCTIBLE | REIMBURSE |
|---|---|---|---|---|---|
| | | RX# | | | |
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## AUTHORIZATION

I certify that the expenses for reimbursement requested from my Health Care Reimbursement Account (HCRA) were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by another plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HCRA. I (or we) understand that expenses reimbursed through the HCRA account can not be used as deductions or credits when filing my (our) income tax return.

Employee Signature _____ Date _____

**Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the detailed prescription receipt.**

***FOR OFFICE USE ONLY***

| Individual Deductible | Family Deductible | Reimburse Amount |
|---|---|---|
| | | |