Health Care Savings Account Reimbursement Request

Attached is documentation of qualified health care expenses that I have incurred for which I am requesting reimbursement from my Health Care Savings Account.

I certify that I have not, and to the best of my knowledge will not, receive reimbursement for these expenses from another source.

The reimbursement amount I am requesting is $ _____.

I understand that

- The reimbursement amount cannot exceed my actual expenditures as shown on the attached documentation.
- If this reimbursement amount is greater than the amount allocated to my Health Care Savings Account for the plan year, minus any prior reimbursements, my actual reimbursement will be reduced to the amount available.
- The qualified expenses must be for goods and services received from January 1 through December 31 of the current plan year and that I must request reimbursement for those expenses by February of the following year.

_____ _____

Employee's Name Date

_____

Employee's Signature