GLYNN GRIFFING & ASSOCIATES, ADMINISTRATORS
REIMBURSEMENT REQUEST FORM

LOGIN TO SUBMIT ONLINE CLAIMS, CHECK ACCOUNT BALANCE AND MORE AT WWW.GLYNN.INFO

DO NOT USE THIS FORM TO SUBSTANTIATE *my*SOURCECARD DEBIT CARD CLAIMS!!

Glynn Griffing & Associates, Administrators
P.O. Box 16509, Jackson, MS 39236-6509
Phone: (601) 982-0331

Total # Pages Faxed

Fax or email your claim:
Fax (601) 981-3829
Email: claims@glynn.info

EMPLOYER NAME: _____

EMPLOYEE NAME: _____ SSN#: _____

ADDRESS, IF CHANGED: _____

EMAIL: _____ PHONE: _____
Used to send important emails about claims

Please complete this form in its entirety. Attach a written statement from an independent third party such as an Itemized Statement, Explanation of Benefits, or Pharmacy Printout of prescriptions filled for each amount claimed. Documentation should include the date of service, the provider of services, what procedure was done, and the amount you are being charged. Charge receipts, Cancelled checks, Balance Forward, Paid on Account Receipts will not be acceptable.

MEDICAL CARE EXPENSES

Date of Service	Name of Person for Whom Expense was Incurred	Relationship to Employee	Name of Entity Providing Service	Description of Services	Reimbursement Amount

DEPENDENT DAY CARE EXPENSES

- **All Dependent Care receipts must include the tax ID number and signature of the provider.**

Beginning Date of Service	Ending Date of Service	Name of Dependent For Whom Expenses Were Incurred	Age of Dependent	Relationship to Employee	Name of Entity Providing Service	Description of Service	Reimbursement Amount

PREMIUM REIMBURSEMENT EXPENSES

Beginning Date of Coverage	Ending Date of Coverage	Name of Dependent For Whom Policy Covers	Relationship to Employee	Name of Insurance Company	Type of Policy	Reimbursement Amount

To the best of my knowledge and belief, the expense(s) listed on this voucher are accurate and complete and are eligible for reimbursement under the Plan. I certify that these expenses will not be claimed again when filing IRS form 1040. I certify that these expenses were incurred for eligible family members. I certify that any Health Premium claimed in my Premium Reimbursement Account is qualified under the terms of the plan.

I certify that any medical or dependent care expenses have not been reimbursed and are not reimbursable under any other coverage. With regard to dependent care expenses, I certify that I will include the name address and taxpayer identification number of the service provider on my income tax return.

I certify that dependent care expenses have not been paid to anyone claimed as a dependent on my income tax return. I certify that if my employer incurs a liability for failure to withhold Federal, State or Local Income taxes or Social Security Taxes on one or more payments or reimbursements that are not Qualifying Expenses, I will indemnify and reimburse the employer that liability on demand.

_____ Employee's Signature

_____ Date